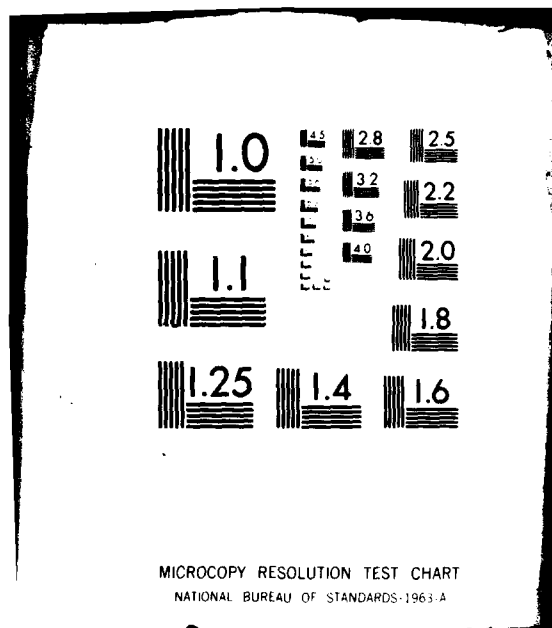


F/G 5/9

TRAINING. APPEN--ETC (1)
N00014-69-C-0246

20





ADA 085706

AD 85 705
LEVEL



DTIC
JUN 19 1980
C

DDC FILE COPY.

This document has been approved
for public release and sale; its
distribution is unlimited.

1

APPENDIX 30.

CURRICULUM FOR

GENERAL HOSPITAL CORPSMAN

APPLICATION OF A SYSTEM APPROACH
U.S. NAVY MEDICAL DEPARTMENT
EDUCATION AND TRAINING PROGRAMS
FINAL REPORT

DTIC
ELECTE
JUN 19 1980
C

Prepared under Contract to
OFFICE OF NAVAL RESEARCH
U.S. DEPARTMENT OF THE NAVY

Quida C. Upchurch, Capt., NC, USN
Program Manager
Education and Training R&D
Bureau of Medicine and Surgery (Code 71G)

This document has been approved
for public release and sale; its
distribution is unlimited.

UNCLASSIFIED

SECURITY CLASSIFICATION OF THIS PAGE (When Data Entered)

REPORT DOCUMENTATION PAGE		READ INSTRUCTIONS BEFORE COMPLETING FORM
1. REPORT NUMBER Final Report (Vols. I & II) Appendix 1-45 30	2. GOVT ACCESSION NO.	3. RECIPIENT'S CATALOG NUMBER
4. TITLE (and Subtitle) A System Approach to Navy Medical Education and Training • Appendix 30 Curriculum for General	5. TYPE OF REPORT & PERIOD COVERED FINAL REPORT	6. PERFORMING ORG. REPORT NUMBER
7. AUTHOR(s) Hospital Corporation	8. CONTRACT OR GRANT NUMBER(s) 15 N00014-69-C-0246	
9. PERFORMING ORGANIZATION NAME AND ADDRESS Office of Naval Research Department of the Navy Arlington, Virginia 22217 31 Aug 74	10. PROGRAM ELEMENT, PROJECT, TASK AREA & WORK UNIT NUMBERS 43-03X.02	
11. CONTROLLING OFFICE NAME AND ADDRESS Office of Naval Research Department of the Navy Arlington, Virginia 22217 12620	12. REPORT DATE 31-8-74	13. NUMBER OF PAGES
14. MONITORING AGENCY NAME & ADDRESS (if different from Controlling Office) Office of Naval Research Department of the Navy Arlington, Virginia 22217	15. SECURITY CLASS. (of this report) UNCLASSIFIED	15a. DECLASSIFICATION/DOWNGRADING SCHEDULE
16. DISTRIBUTION STATEMENT (of this Report) Approved for public release; distribution unlimited.		
17. DISTRIBUTION STATEMENT (of the abstract entered in Block 20, if different from Report) Approved for public release; distribution unlimited.		
18. SUPPLEMENTARY NOTES None		
19. KEY WORDS (Continue on reverse side if necessary and identify by block number) Education and Training Medical Technician Medical Training Job Analysis Nurse Training Task Analysis Dentist Training Curriculum Development		
20. ABSTRACT (Continue on reverse side if necessary and identify by block number) The study objective consisted of a determination of what the health care personnel in the Navy's Medical Department, Bureau of Medicine and Surgery actually do in their occupations; improving the personnel process (education and training); and building a viable career pathway for all health care personnel. Clearly the first task was to develop a system of job analyses applicable to all system wide health care manpower tasks. A means of postulating simplified occupational clusters covering some 50.		

DD FORM 1473
1 JAN 73EDITION OF 1 NOV 68 IS OBSOLETE
S/N 0102-014-6601

UNCLASSIFIED

SECURITY CLASSIFICATION OF THIS PAGE (When Data Entered)

388 930

UNCLASSIFIED

SECURITY CLASSIFICATION OF THIS PAGE(When Data Entered)

currently designated Navy enlisted occupations, 20 Naval Enlisted Classification Codes (NEC's) were computerized. A set of 16 groupings that cover all designated occupations was developed so as to enhance the effectiveness of professionals and sub-professionals alike.

Accession For		<input checked="checked" type="checkbox"/>
NEC's		<input type="checkbox"/>
DEC's		<input type="checkbox"/>
Unassigned		
Justification		
By		
Distribution		
Availability		
Dist	Available for special	

UNCLASSIFIED

SECURITY CLASSIFICATION OF THIS PAGE(When Data Entered)

FOREWORD

The project, "Application of a System Approach to the Navy Medical Department Education and Training Programs," was initiated in May of 1969 as a realistic, comprehensive response to certain objectives set forth in ADO 43-03X, and to memoranda from both the Secretary of Defense and the Assistant Secretary of Defense, Manpower and Reserve Affairs. The Secretary's concern was stated in his memorandum of 29 June 1965, "Innovation in Defense Training and Education." More specific concerns were stated in the Assistant Secretary's memorandum of 14 June 1968, "Application of a System Approach in the Development and Management of Training Courses." In this he called for "vigorous and imaginative effort," and an approach "characterized by an organized training program with precise goals and defined operational interrelation among instructional system components." He also noted, "Job analyses with task descriptions expressed in behavioristic terms are basic and essential to the development of precise training goals and learning objectives."

The Project

System survey and analysis was conducted relative to all factors affecting education and training programs. Subsequently, a job-analysis sub-system was defined and developed incorporating a series of task inventories "... expressed in behavioristic terms ..." These inventories enabled the gathering of job activity data from enlisted job incumbents, and data relating to task sharing and delegation from officers of the Medical, Nurse and Dental Corps. A data management sub-system was devised to process incumbent data, then carry out needed analyses. The development of initial competency curricula based upon job analysis was implemented to a level of methodology determination. These methods and curriculum materials constituted a third (instructional) sub-system.

Thus, as originally proposed, a system capability has been developed in fulfillment of expressed needs. The system, however, remains untested and unevaluated. ADO 43-03X called for feasibility test and cost-effectiveness determination. The project was designed to so comply. Test and evaluation through the process of implementation has not proved feasible in the Navy Medical Department within the duration of the project. As designed and developed the system does have "... precise goals and defined operational interrelation among instructional system components." The latter has been achieved in terms of a recommended career structure affording productive, rewarding manpower utilization which bridges manpower training and health care delivery functions.

Data Management Sub-System

Job analysis, involving the application of comprehensive task inventories to thousands of job incumbents, generates many millions of discrete bits of response data. They can be processed and manipulated only by high speed computer capability using rigorously designed specialty programs. In addition to numerical data base handling, there is the problem of rapidly and accurately manipulating a task statement data base exceeding ten thousand carefully phrased behavioral statements. Through the use of special programs, task inventories are prepared, printouts for special purposes are created following a job analysis application, access and retrieval of both data and tasks are efficiently and accurately carried out, and special data analyses conducted. The collective programs, techniques and procedures comprising this sub-system are referred to as the Navy Occupational Data Analysis Language (NODAL).

Job Analysis Sub-System

Some twenty task inventory booklets (and associated) response booklets) were the instruments used to obtain job incumbent response data for more than fifty occupations. An inventory booklet contains instructions, formatted questions concerning respondent information ("bio-data"), response dimension definitions, and a list of tasks which may vary in number from a few hundred to more than a thousand per occupational field.

By applying NODAL and its associated indexing techniques, it is possible to assemble modified or completely different inventories than those used in this research. Present inventories were applied about three years ago. While they have been rendered in operational format, they should not be reapplied until their task content is updated.

Response booklets were designed in OPSCAN mode for ease of recording and processing responses.

Overall job analysis objectives and a plan of administration were established prior to inventory preparation, including the setting of provisional sample target sizes. Since overall data attrition was forecast to approximate twenty percent, final sample and sub-sample sizes were adjusted accordingly. Stratified random sampling techniques were used. Variables selected (such as rating, NEC, environment) determined stratifications, together with sub-population sizes. About fifteen percent of large sub-populations were sought while a majority of all members of small sub-populations were sought.

Administration procedures were established with great care for every step of the data collecting process, and were coordinated with sampling and data analysis plans. Once set, the procedures were formalized as a protocol and followed rigorously.

Instructional Sub-System

Partial "competency curricula" have been composed as an integral sub-system bridging what is required as performance on the job with what is, accordingly, necessary instruction in the training process. Further, curriculum materials were developed to meet essential requirements for implementing the system so that the system could be tested and evaluated for cost effectiveness. However, due to the fact that test and evaluation was not feasible in the Navy Medical Department within the duration of the project, it was not possible to complete the development of the system through the test and evaluation phase. The inability to complete this phase also interrupted the planned process for fully developing the curricula; therefore, instead of completed curricula ready for use in the system, the curricula were partially developed to establish the necessary sub-system methodology. The competency curricula are based on tasks currently performed by job incumbents in 1971. (The currency of a given curriculum depends upon periodic analysis of incumbents' jobs, and its quality control resides in the evaluation of the performance competency of the program's graduates.)

A competency curriculum provides a planned course of instruction or training program made up of sequenced competency units which are, in turn, comprised of sequenced modules. These modules, emphasizing performance objectives, are the foundation of the curriculum.

A complete module would be comprised of seven parts: a cluster of related tasks; a performance objective; a list of knowledges and skills implied by the objective; a list of instructional strategies for presenting the knowledges and skills to the learner; an inventory of training aids for supporting the instructional strategies; a list of examination modes; and a statement of the required training time. In this project, curriculum materials have been developed to various levels of adequacy, and usually comprise only the first three parts; the latter four need to be prepared by the user.

The performance objective, which is the most crucial part of the module, is the basis for determining curriculum content. It is composed of five essential elements: the stimulus which initiates the behavior; the behavior; the conditions under which the behavior takes place; the criteria for evaluating the behavior; and the consequence or results of the behavior. A sixth element, namely next action, is not essential; however, it is intended to provide linkage for the next behavior.

Knowledges and skills listed in the module are those needed by the learner for meeting the requirements of the performance objective.

Instructional strategies, training aids, examination modes and training time have been specified only for the Basic Hospital Corps Curriculum. The strategies, aids and modes were selected on the basis of those considered to be most supportive in presenting the knowledges and skills so as to provide optimum learning effectiveness and training efficiency. The strategies extend from the classroom lecture as traditionally presented by a teacher to the more sophisticated mediated program for self-instruction. The training aids, like strategies, extend from the traditional references and handout material in the form of a student syllabus to mediated programs for self-instruction supported by anatomical models. Examination modes extend from the traditional paper and pencil tests to proficiency evaluation of program graduates on the job, commonly known as feedback. Feedback is essential for determining learning effectiveness and for quality control of a training program. The kind of instructional strategies, training aids and examination modes utilized for training are limited only by such factors as staff capability and training budget.

The training time specified in the Basic Hospital Corps Curriculum is estimated, based upon essential knowledge and skills and program sequence.

The competency curriculum module, when complete, provides all of the requirements for training a learner to perform the tasks set forth in the module. A module may be used independently or related modules may be re-sequenced into modified competency units to provide training for a specific job segment.

Since the curricula are based upon tasks performed by job incumbents in 1971, current analysis of jobs needs to be accomplished using task inventories that have been updated to reflect changes in performed tasks. Subsequent to job analysis, a revision of the curricula should be accomplished to reflect task changes. When the foregoing are accomplished, then faculty and other staff members may be indoctrinated to the competency curricula and to their relationship to the education and training system.

In addition to the primary use for the systematic training of job incumbents, these curricula may be used to plan for new training programs, develop new curricula, and revise existing curricula; develop or modify performance standards; develop or modify proficiency examinations; define billets; credentialize training programs; counsel on careers; select students; and identify and select faculty.

The System

Three sub-systems, as described, comprise the proposed system for Education and Training Programs in the Navy Medical Department. This exploratory and advanced developmental research has established an overall methodology for improved education and training incorporating every possible means of providing bases for demonstrating feasibility and cost effectiveness. There remains only job analysis sub-system up-dating, instructional sub-system completion, and full system test and evaluation.

Acknowledgements

The authors wish to acknowledge the invaluable participation of the several thousands of Naval personnel who served as respondents in inventory application. The many military and civilian personnel who contributed to developmental efforts are cited by name in the Final Report.

The authors also wish to acknowledge former colleagues for singularly important contributions, namely, Elias H. Porter, Ph.D., Carole K. Kauffman, R.N., M.P.H., Mary Kay Munday, B.S.N., R.N., Gail Zarren, M.S.W., and Renee Schick, B.A.

Identity and acknowledgement of the project Advisory Group during the project's final year is recorded in the Final Report.

Lastly, the project could not have been commenced nor carried out without the vision, guidance and outstanding direction of Ouida C. Upchurch, Capt., NC, USN, Project Manager.

TABLE OF CONTENTS

<u>Unit</u>	<u>Page</u>
IA	INTRODUCTION TO THE FUNDAMENTALS OF ANATOMY AND PHYSIOLOGY
	1
	IA1. Body Structure
	3
	IA2. The Skeletal System
	5
	IA3. The Muscular System
	6
	IA4. The Circulatory System
	7
	IA5. The Respiratory System
	8
	IA6. The Digestive System
	9
	IA7. The Excretory System
	10
	IA8. The Reproductive System
	11
	IA9. The Endocrine System
	12
	IA10. The Nervous System
	13
	IA11. The Special Senses
	14
IB	REVIEW OF BASIC MATHEMATICS
	15
	IB1. Basic Mathematical Computations
	17
	IB2. Systems of Measurement and Their Computation
	18
IC	ORIENTATION TO THE NAVY MEDICAL DEPARTMENT
	19
	IC1. Orientation to the Navy Medical Department
	21
ID	INTRODUCTION TO OBSERVATION, COMMUNICATION, AND INSTRUCTIONAL SKILLS
	23
	ID1. Basic Observation Skills Essential to Patient Care . .
	26
	ID2. Basic Communication Skills Essential to Patient Care
	30
	ID3. Fundamentals in Teaching the Patient
	38
IE	GIVING GENERAL PATIENT CARE
	41
	IE1. The Patient's Unit: Preparation and Maintenance . . .
	46
	IE2. Patient Care: Preliminary Steps
	49
	IE3. Patient Care: Interaction During Care
	52
	IE4. Patient Care: Reporting and Recording
	55
	IE5. Patient Care: Washing and Scrubbing of the Hands . .
	58
	IE6. Patient Care: Moving and Positioning Patient
	61
	IE7. Patient Care: Moving and Transporting Patient
	64
	IE8. Patient Care: Clothing the Patient and Monitoring Apparel
	67
	IE9. Patient Care: Making an Occupied Bed
	70

TABLE OF CONTENTS (Continued)

<u>Unit</u>		<u>Page</u>
	IE10. Patient Care: Oral Hygiene and Mouth Irrigation . . .	73
	IE11. Patient Care: Nail and Hair Care	76
	IE12. Patient Care: Bathing the Patient	79
	IE13. Patient Care: Diets and Nutrition	82
	IE14. Patient Care: Serving Meals and Nourishment	85
	IE15. Patient Care: Assisting the Patient To Eat and Feeding the Patient	88
	IE16. Patient Care: Assisting the Patient with Elimination	91
	IE17. Patient Care: Rest and Sleep	94
	IE18. Patient Care: Activity and Exercise	97
	IE19. Patient Care: Observations of Patient Behavior . . .	99
	IE20. Patient Care: Safety and Restraint	102
	IE21. Patient Care: Recreation	105
	IE22. Patient Care: Patients with Communication Problems	107
	IE23. Patient Care: Measure and Weigh Patients	110
	IE24. Patient Care: Security of Patient's Property	113
	IE25. Patient Care: Very Seriously Ill and Dying Patients	115
	IE26. Post Mortem Care	118
IF	COLLECTING AND HANDLING SPECIMENS AND LABORATORY REPORTS	121
	IF1. Specimens: Collecting and Handling of Voided Urine	125
	IF2. Specimens: Collecting and Handling of Feces	128
	IF3. Specimens: Collecting and Handling of Upper Respiratory Tract and Ear Secretions	132
	IF4. Specimens: Collecting and Handling of Drainage from Body Orifices and Open Wounds	136
	IF5. Specimens: Collecting and Handling of Blood	140
	IF6. Specimens: Collecting and Handling of Specimens not Ordered	144
	IF7. Specimens: Follow-Up on Laboratory Reports	147
IG	CARDIOVASCULAR DYSFUNCTIONS: DIAGNOSTIC, THERAPEUTIC, AND REHABILITATIVE PROCEDURES	149
	IG1. Patient's Temperature: Take	152
	IG2. Patient's Pulse and Respiration: Count and Describe	156
	IG3. Blood Pressure: Take	160
	IG4. Venous Pressure: Measure	164
	IG5. Edema: Examination for and Supportive Treatment . . .	168
	IG6. Tourniquets in Pulmonary Edema	172

TABLE OF CONTENTS (Continued)

<u>Unit</u>		<u>Page</u>
IH	DRUG THERAPY AND ADMINISTRATION OF MEDICATIONS	176
IH1.	Drugs: Information, Controlling Laws, and Policies	180
IH2.	Drugs: Patient Response and Care	183
IH3.	Drugs: Maintenance and Security on Patient Care Unit	187
IH4.	Drugs: Ordering from the Pharmacy	190
IH5.	Transcription of Doctor's Orders	193
IH6.	Drugs: Dosage Calculation and Measurement	196
IH7.	Medications: Administration of Oral	199
IH8.	Medications: Administration of Topical	203
IH9.	Medications: Administration by Instillation and Insertion	207
IH10.	Medications: Administration of Subcutaneous and Intramuscular	211
IH11.	Medications: Administration of Intravenous	215
IH12.	Medications: Administration of Inoculations, Vaccinations, and Skin Tests	219
IH13.	Medications: Instruction to Patient for Self-Administration	223
I-I	PATIENT HYDRATION AND BLOOD TRANSFUSIONS	226
I-I1.	Fluid Balance: Intake and Output	230
I-I2.	Fluid Balance: Administration of Subcutaneous Fluids (Hypodermoclysis)	234
I-I3.	Fluid Balance: Administration of Intravenous Fluids	238
I-I4.	Blood Transfusion: Administration of	243
IJ	APPLICATION OF EXTERNAL HEAT AND COLD	248
IJ1.	Application of External Heat	251
IJ2.	Application of External Cold	255
IK	CONTROLLING THE SPREAD OF DISEASE AND INFECTION	259
IK1.	Putting on Surgical Gloves	262
IK2.	Using a Face or Surgical Mask	264
IK3.	Using a Surgical and Isolation Gown	266
IK4.	Preparation of Isolation Units	268
IK5.	Isolating and Caring for the Patient	271
IK6.	Cleaning and Terminal Disinfection of the Isolation Unit	275

TABLE OF CONTENTS (Continued)

<u>Unit</u>		<u>Page</u>
IL	MANAGEMENT OF PATIENT CARE	278
	IL1. The Patient's Records: Preparation, Maintenance, and Disposition	281
	IL2. The Patient's Nursing Care Plan: Preparation, Maintenance, and Disposition	285
	IL3. The Admission of a Patient to the Ward Unit	288
	IL4. The Transfer of a Patient Between Ward Units	292
	IL5. The Discharge of a Patient from the Hospital	296
	IL6. Doctors Rounds or Sick Call on the Ward Unit	299
	IL7. Interdepartmental Coordination of Patient Care	303
	IL8. Patient Care Rounds on the Ward Unit	306
IM	EMERGENCIES: EXAMINATION AND TREATMENT	310
	IM1. Convulsions: Examination and Emergency Treatment	315
	IM2. Unconsciousness: Examination and Emergency Treatment	319
	IM3. Inebriation: Examination and Emergency Treatment	324
	IM4. Food Poisoning: Examination and Emergency Treatment	328
	IM5. Poisoning: Examination and Emergency Treatment	334
	IM6. Respiratory Emergencies: Examination of	339
	IM7. Respiratory Emergencies: Treatment for Obstructions and Mechanical Interferences	343
	IM8. Respiratory Emergencies: Administration of Artificial Respiration	347
	IM9. Application of Binders, Bandages, and Strapping	351
	IM10. Hemorrhage: Examination of	355
	IM11. Hemorrhage: Emergency Treatment for	359
	IM12. Shock: Examination for	363
	IM13. Shock: Emergency Treatment for	367
	IM14. Wounds: Emergency Treatment for	371
	IM15. Wounds: Emergency Suturing of	376
	IM16. Internal Injuries: Examination for	380
	IM17. Internal Injuries: Emergency Treatment for	385
	IM18. Strains, Sprains, and Dislocations: Examination and Emergency Treatment	389
	IM19. Fractures: Examination and Emergency Treatment for	393
	IM20. Spinal Cord and Head Injuries: Examination and Emergency Treatment	398
	IM21. Burns: Examination and Emergency Treatment	402
	IM22. Heat Cramps, Heat Exhaustion, and Heat Stroke: Examination and Emergency Treatment	406

TABLE OF CONTENTS (Continued)

<u>Unit</u>		<u>Page</u>
	IM23. Cold Injury: Examination and Emergency Treatment . .	411
	IM24. Bites and Stings: Examination of	415
	IM25. Bites and Stings: Emergency Treatment for	419
	IM26. Acute Heat Conditions: Examination of	423
	IM27. Acute Heat Conditions: Treatment for	428
	IM28. Moving and Transporting Emergency Cases	432
IN	SKIN DYSFUNCTIONS: DIAGNOSTIC, THERAPEUTIC, AND REHABILITATIVE PROCEDURES	436
	IN1. Skin Diseases: Observation, Examination, and Tentative Diagnosis	440
	IN2. Skin Specimens: Collecting and Handling Skin Scrape	444
	IN3. Skin Specimens: Collecting and Handling Skin Biopsy	447
	IN4. Skin: Decubiti Care	451
	IN5. Skin: Comedo Sebaceous Material Extraction	455
IO	RESPIRATORY DYSFUNCTIONS: DIAGNOSTIC, THERAPEUTIC AND REHABILITATIVE PROCEDURES	459
	IO1. Respiratory: Observation for Abnormal Functions and Symptoms of Disease	463
	IO2. Throat Irrigations and Gargles: Administration of	466
	IO3. Oxygen, Carbon Dioxide, and Humidity Therapy	470
	IO4. Intermittent Positive Pressure Breathing Therapy	475
	IO5. Upper Respiratory Tract: Suctioning of	479
	IO6. Chest Physical Therapy	483
	IO7. Tracheotomy Care	487
IP	GASTROINTESTINAL DYSFUNCTIONS: DIAGNOSTIC, THERAPEUTIC AND REHABILITATIVE PROCEDURES	491
	IP1. Observation and Examination of Gastrointestinal Conditions	495
	IP2. Colostomy and Ileostomy Care	499
	IP3. Gastrointestinal Intubation	503
	IP4. Feedings by Gastrointestinal Tube	508
	IP5. Gastrointestinal Irrigations	512
	IP6. Gastrointestinal Drainage With and Without Suction	516
	IP7. Lower Bowel Therapeutic Measures	520
	IP8. Gastrointestinal Tests and Examinations: Preparation for	524

TABLE OF CONTENTS (Continued)

<u>Unit</u>		<u>Page</u>
IQ	URINARY DYSFUNCTIONS: DIAGNOSTIC, THERAPEUTIC, AND REHABILITATIVE PROCEDURES	528
	IQ1. Observations and Examinations of Urinary Conditions	532
	IQ2. Assisting the Patient To Void by Credé Method	536
	IQ3. Catheterization of the Urinary Bladder	540
	IQ4. Urine Specimens: Collecting and Handling of Sterile	544
	IQ5. Urinary Gravity and Decompression Drainage	548
	IQ6. Urinary Tract Irrigations	552
	IQ7. Urinary Tract Diagnostic Tests and Examinations: Preparations for	556
	IQ8. Urine Specimens: Collecting and Handling of Urine for Special Tests	560
	IQ9. Urine Test: Performed in Patient Care Unit	564
IR	CARE OF THE SURGICAL PATIENT	568
	IR1. Surgical Wounds: Observation and Examination of Dressings	572
	IR2. Preoperative Preparation of the Patient	576
	IR3. Postoperative Unit: Preparation of	581
	IR4. Patient Care: Postoperative	584
	IR5. Surgical Wounds: Changing Dressings	589
	IR6. Surgical Wounds: Packing and Drains	593
	IR7. Surgical Wounds: Irrigations	597
	IR8. Surgical Wounds: Suture Removal	601

TRAINING UNIT IA
INTRODUCTION TO THE FUNDAMENTALS OF ANATOMY AND PHYSIOLOGY

Learning Modules

- IA1. Body Structure
- IA2. The Skeletal System
- IA3. The Muscular System
- IA4. The Circulatory System
- IA5. The Respiratory System
- IA6. The Digestive System
- IA7. The Excretory System
- IA8. The Reproductive System
- IA9. The Endocrine System
- IA10. The Nervous System
- IA11. The Special Senses

Training Objective

Upon completion of this training unit the learner must have a basic knowledge of the fundamentals of anatomy and physiology. He must be able to demonstrate the use of this knowledge in subsequent training units of his Basic Hospital Corps program and in giving patients care in naval medical activities and in emergencies.

Knowledge and Skills

1. Use anatomical and physiological terms commonly applied in patient care.
2. Identify normal body structure and functions as related to patient care.

Instructional Strategies

1. Mediated programmed instruction for total training unit
2. Hardcover programmed instruction for total training unit
3. Films, filmstrips, and videotapes supported by workbooks for total training unit
4. Lecture

5. Discussion
6. Study assignments
7. Written exercises

Training Aids

1. Films, filmstrips and videotapes
2. Slides
3. Mediated programmed instruction
4. Hardcover programmed instruction
5. Anatomical charts
6. Anatomical models
7. Chalk board
8. Instructor's guide
9. Student syllabus
10. References

Examination Modes

1. Response in classroom
2. Paper and pencil tests
3. Application in subject training units of program
4. Application in work situation and in emergencies (feedback)
5. Oral query on knowledge related to performance in simulated practice and in work situation (feedback)

Training Time

24:00 hours didactic

LEARNING MODULE 1A1

BODY STRUCTURE

- a. Cells--basic element
 - 1. Structure
 - 2. Characteristics
- b. Tissues--composed of groups of cells performing particular function
 - 1. Epithelial--location and function
 - 2. Connective--location and function
 - 3. Muscular--location and function
 - 4. Nervous--location and function
 - 5. Blood and lymph--free flowing cells in body fluids
- c. Organs
 - 1. Composed of several different types of tissue, each performing special tasks
- d. Cavities
 - 1. Dorsal (cranial enlargement)--location and contents
 - 2. Nasal--location and contents
 - 3. Buccal--location and contents
 - 4. Thoracic--location and contents
 - 5. Abdominal--location and contents
 - 6. Dorsal (spinal portion)--location and contents
 - 7. Pelvic--location and contents
- e. Systems--composed of groups of organs
 - 1. Skeletal--composition
 - 2. Muscular--composition
 - 3. Circulatory--composition
 - 4. Respiratory--composition
 - 5. Digestive--composition
 - 6. Excretory--composition
 - 7. Reproductive--composition

8. Endocrine--composition

9. Nervous--composition

f. Anatomical Terms

1. Anatomical planes--posterior, anterior, cranial, caudal, median, sagittal

2. Anatomical position--anterior, posterior, medial, lateral, internal, external, proximal, distal, superior, inferior, cranial, caudal

3. Body positions--erect, supine, prone, lateral, recumbent

Training Time

2:00 hours didactic

LEARNING MODULE IA2
THE SKELETAL SYSTEM

- a. General functions of the skeletal system
 - 1. Protection and support of less rigid and more fragile body organs
 - 2. Attachment for muscles to produce locomotion
 - 3. Provide for vertical posture in man allowing freedom of upper extremities
- b. Bones
 - 1. Structure
 - 2. Composition
 - 3. Classification
- c. Skull
 - 1. Cranial bones--structure and function
 - 2. Facial bones--structure and function
- d. Vertebral column
 - 1. Structure and function
 - 2. Five spinal column regions
- e. The thorax
 - 1. Structure and functions
- f. Upper extremities
 - 1. Structure and function
 - 2. Bones in upper extremity framework
- g. Lower extremities
 - 1. Structure and function
 - 2. Bones in lower extremity framework
- h. Joints
 - 1. Location, structure and function
 - 2. Types of joint movements

Training Time

2:00 hours didactic

LEARNING MODULE 1A3
THE MUSCULAR SYSTEM

- a. General functions of muscular system
 - 1. Provides force that moves skeleton
 - 2. Supplies support for body organs
 - 3. Keeps body erect
 - 4. Aids body cavities in holding body organs in position
- b. Types of muscles
 - 1. Voluntary or skeletal
 - 2. Involuntary or smooth
- c. Skeletal muscles
 - 1. Structure and function
 - 2. Attachment
 - 3. Flexor and extensor muscular action
 - 4. Muscle groups--shoulder, arm and hand, respiration, abdominal, vertebral and leg
- d. Smooth muscle
 - 1. Location
 - 2. Structure and function
 - 3. Controlled by the nervous system
- e. Bursae
 - 1. Location
 - 2. Structure and function

Training Time

2:00 hours didactic

LEARNING MODULE IA4
THE CIRCULATORY SYSTEM

- a. General functions of circulatory system
 - 1. Supply food and oxygen to body cells
- b. Blood
 - 1. Composition--plasma and cells
 - 2. Functions--carries to cells food, oxygen, water and hormones; away from cells, waste
 - 3. Blood cells and their function
 - 4. Blood plasma and serum
 - 5. Blood coagulation--normal clotting time
- c. Blood vessel system
 - 1. Arteries--composition, structure, function
 - 2. Capillaries--composition, structure, function
 - 3. Veins--composition, structure, function
 - 4. Major blood vessels
- d. Heart
 - 1. Structure and function
 - 2. Coverings
- e. Pulse, pulse pressure, blood pressure
 - 1. Normal range
 - 2. Significance of each
- f. Lymph and lymph-vascular system
 - 1. Lymph
 - 2. Lymph-vascular system
 - 3. Lymph vessels
 - 4. Lymph glands/nodes

Training Time

3:00 hours didactic

LEARNING MODULE IA5
THE RESPIRATORY SYSTEM

- a. General function of respiratory system
 - 1. Exchange of gases--oxygen and carbon dioxide
- b. Respiratory organs
 - 1. Nose--structure and function
 - 2. Pharynx--structure and function
 - 3. Larynx--structure and function
 - 4. Trachea--structure and function
 - 5. Bronchi--structure and function
 - 6. Lungs--structure and function
 - 7. Mediastinum--structure and function
- c. Respiratory process
 - 1. Inspiration
 - 2. Expiration
 - 3. Respiratory rate
- d. Type of breathing
 - 1. Eupnea
 - 2. Dyspnea
 - 3. Hyperpnea
 - 4. Apnea
 - 5. Cheyne-Stokes
 - 6. Edematous
 - 7. Asphyxia

Training Time

2:00 hours didactic

LEARNING MODULE 1A6
THE DIGESTIVE SYSTEM

- a. General functions of digestive system
 - 1. Food ingestion
 - 2. Food digestion
 - 3. Food metabolism
 - 4. Waste elimination
- b. Structure and function
 - 1. The abdominal cavity
 - 2. The peritoneum
 - 3. Alimentary canal--mucous, muscular, fibrous layers
- c. Alimentary canal--structure and functions
 - 1. Mouth--teeth and tongue
 - 2. Pharynx
 - 3. Esophagus
 - 4. Stomach
 - 5. Small intestine, duodenum, jejunum, ileum
 - 6. Large intestine, cecum, ascending colon, transverse colon, sigmoid colon
 - 7. Rectum
 - 8. Anus
 - 9. Accessory organs--salivary glands, pancreas, liver, gallbladder, intestinal glands
- d. Absorption of food
 - 1. Protein and carbohydrate
 - 2. Fat

Training Time

3:00 hours didactic

LEARNING MUDULE IA7
THE EXCRETORY SYSTEM

- a. General functions of excretory system
 - 1. Waste excretions
- b. Excretory organs of the body
 - 1. Kidneys
 - 2. Skin (sweat glands)
 - 3. Lungs
 - 4. Intestines
- c. Urinary system
 - 1. Kidneys--structure and functions
 - 2. Ureters--structure and functions
 - 3. Urinary bladder--structure and functions
 - 4. Urethra
- d. Skin
 - 1. Structure and function
 - 2. Sweat glands
 - 3. Sebaceous glands

Training Time

2:00 hours didactic

LEARNING MODULE IA8
THE REPRODUCTIVE SYSTEM

- a. General function of reproductive system
 - 1. Procreation--bring new life into the world
- b. Female reproductive system
 - 1. External genitals--structure and function
 - 2. Vagina--structure and function
 - 3. Uterus--structure and function
 - 4. Fallopian tubes--structure and function
 - 5. Ovaries--structure and function
 - 6. Breasts and mammary glands--structure and function
- c. Male reproductive system
 - 1. Scrotum--structure and function
 - 2. Testes--structure and function
 - 3. Spermatic cords--structure and function
 - 4. Ductus deferens--structure and function
 - 5. Seminal vesicles--structure and function
 - 6. Ejaculatory duct--structure and function
 - 7. Prostate gland--structure and function
 - 8. Cowper's gland--structure and function
 - 9. Urethra--structure and function
 - 10. Penis--structure and function

Training Time

2:00 hours didactic

LEARNING MODULE IA9
THE ENDOCRINE SYSTEM

- a. General functions of the endocrine system
 - 1. Excrete hormones to regulate body functions
- b. Location, structure and functions of endocrine system glands
 - 1. Spleen
 - 2. Thyroid
 - 3. Parathyroid
 - 4. Adrenal
 - 5. Pituitary
 - 6. Gonads
 - 7. Pancreas
 - 8. Intestinal
 - 9. Pineal
 - 10. Thymus

Training Time

2:00 hours didactic

LEARNING MODULE IA10
THE NERVOUS SYSTEM

- a. General function of the nervous system
 - 1. Controls body activities
- b. Nerves
 - 1. Types and function--tropic, motor, sensory
 - 2. Structure
- c. Central nervous system
 - 1. Brain--structure and function
 - 2. Spinal cord--structure and function
 - 3. Cerebrospinal fluid
 - 4. Peripheral nervous system (cranial and spinal nerves) structure
- d. Autonomic nervous system
 - 1. Sympathetic system--structure and function
 - 2. Parasympathetic system--structure and function

Training Time

3:00 hours didactic

LEARNING MODULE IA11

THE SPECIAL SENSES

- a. Smell
 - 1. Function of olfactory membrane of nose
- b. Taste
 - 1. Function of taste buds of mouth
 - 2. The four tastes
- c. Sight
 - 1. General function of eye
 - 2. Structures of the eye and their functions
- d. Hearing
 - 1. Parts of the ear and their functions in hearing
- e. Touch
 - 1. Perception of feeling, e.g., soft or hard, cold or hot
 - 2. Carried through nerve ending of skin
- f. The five senses
 - 1. Coordinate functions, e.g., smell and taste, hearing and touch, sight and touch
 - 2. Tools for observation

Training Time

1:00 hour didactic

TRAINING UNIT IB
REVIEW OF BASIC MATHEMATICS

Learning Modules

- IB1. Basic Mathematical Computations
- IB2. Systems of Measurement and Their Computation

Training Objective

Upon completion of this training unit the learner must be able to perform basic mathematical computations requiring addition, subtraction, multiplication, and division including decimals and fractions. He must be able to use the metric, apothecary and avoirdupois systems of measurement and their equivalencies in computing weights and volume, ratio, proportion and percentage solutions. The learner must also be able to accomplish all computations correctly without supervision or assistance. This knowledge will enable him to compute medication dosage and to convert measurement from one system to another one.

Knowledge and Skills

1. Use of addition, subtraction, multiplication and division as required.
2. Handling of fractions, decimals, percentage.
3. Metric, apothecary, and avoirdupois systems and their equivalencies.
4. Specific volume and specific weight.
5. Computation of measurement in volume and weight.
6. Computation of ratio, proportion and percentage solutions.
7. Reduction of higher to lower denomination.

Instructional Strategies

1. Mediated programmed instruction
2. Hardcover programmed instruction
3. Lecture
4. Discussion

5. Demonstration
6. Study assignments
7. Written exercises

Training Aids

1. Mediated programmed instruction
2. Hardcover programmed instruction
3. Chalk board
4. Instructor's guide
5. Student syllabus
6. References

Examination Modes

1. Response in classroom
2. Paper and pencil test
3. Application in simulated administration of medications

Training Time

8:00 hours didactic

LEARNING MODULE IB1
BASIC MATHEMATICAL COMPUTATIONS

- a. Mathematical functions
 - 1. Addition
 - 2. Subtraction
 - 3. Multiplication
 - 4. Division
- b. Handling of fractions
 - 1. Addition
 - 2. Subtraction
 - 3. Multiplication
 - 4. Division
- c. Handling of decimals
 - 1. Addition
 - 2. Subtraction
 - 3. Multiplication
 - 4. Division
- d. Percentage and its relationship to fractions
 - 1. Conversion of percentage to fractions
 - 2. Conversion of fractions to percentages

Training Time

3:00 hours didactic

LEARNING MODULE IB2
SYSTEMS OF MEASUREMENT AND THEIR COMPUTATION

- a. Systems
 - 1. Metric
 - 2. Apothecary
 - 3. Avoirdupois
 - 4. Equivalency tables
- b. Specific gravity
 - 1. Definition
 - 2. Formula
- c. Specific volume
 - 1. Definition
 - 2. Formula
- d. Computation in measurement
 - 1. Weights and volume--addition, subtraction, multiplication and division
 - 2. Weight to volume and volume to weight
 - 3. Ratio
 - 4. Proportion
 - 5. Reduction of higher to lower denomination
 - 6. Percentage solutions

Training Time

5:00 hours didactic

TRAINING UNIT IC
ORIENTATION TO THE NAVY MEDICAL DEPARTMENT

Learning Module

IC1. Orientation to the Navy Medical Department

Training Objective

Upon completion of this training unit the learner must be familiar with the mission, organization, and chain of command from the Department of Defense down through the naval hospital and clinic. He must be able to recognize the personnel components of the Navy Medical Department and their relationship, and he must be able to understand the organization and functions of the patient care team. He must be familiar with the Hospital Corps and its relationship to him and his Navy career. He must be able to recognize patient categories as related to hospitals, clinics, and sick call.

Knowledge and Skills

1. Mission and organization of Department of Defense, The Department of the Navy, Navy Medical Department, Naval Medical Regional Commands, naval hospital and clinic, Navy Medical Department as related to the operating forces.
2. Chain of command
3. Personnel components of Naval Medical Department
4. Hospital Corps and Hospital Corpsman's career
5. Patient care team
6. The patient

Instructional Strategies

1. Hardcover programmed instruction
2. Lecture
3. Discussion
4. Study assignments
5. Written exercises

Training Aids

1. Hardcover programmed instruction
2. Slides
3. Organizational charts
4. Chalk board
5. Instructor's guide
6. Student syllabus
7. References

Examination Modes

1. Response in classroom
2. Paper and pencil test
3. Application in work situation (feedback)

Training Time

4:00 hours didactic

LEARNING MODULE IC1
ORIENTATION TO THE NAVY MEDICAL DEPARTMENT

- a. Department of Defense
 - 1. Mission
 - 2. Organization
- b. The Department of the Navy
 - 1. Mission
 - 2. Organization
- c. The Navy Medical Department
 - 1. Mission
 - 2. Organization--Bureau of Medicine and Surgery, shore activities, fleet activities
 - 3. Relationship to other Bureaus and Commands
 - 4. Composition--Military: Medical, Dental, Medical Service, and Hospital Corps--Civilian: professional, technical, and support
- d. Navy Medical Regional Commands
 - 1. Mission
 - 2. Organization
 - 3. Relationship to hospitals, clinics, and other medical activities
- e. Naval Hospitals
 - 1. Mission
 - 2. Organization--command, administrative, and professional
 - 3. Hospitals--location
- f. Navy Medical Clinics
 - 1. Mission
 - 2. Organization--command, administrative, professional
 - 3. Clinics--location

g. Fleet and Marine Corps Support

1. Large ships
2. Small ships
3. Marine Corps forces

h. Patient Care Team

1. Composition--doctor, nurse, and corpsman
2. Mission
3. Organization--chain of command

i. Hospital Corps

1. History
2. Organization
3. Rates
4. Specialties
5. Functions
6. Proficiency ratings
7. Advancement/promotion system
8. Education and training opportunities
9. Pay and allowances
10. Enlistment, reenlistment, retirement

j. The patient

1. Patient categories--military personnel and retired and their dependents; veterans; others
2. Hospital--by type
3. Clinic
4. Sick call

Training time

4:00 hours didactic

TRAINING UNIT ID
INTRODUCTION TO OBSERVATION, COMMUNICATION, AND INSTRUCTIONAL SKILLS

Learning Modules

- ID1: Basic Observation Skills Essential to Patient Care
- ID2: Basic Communication Skills Essential to Patient Care
- ID3: Fundamentals in Teaching the Patient

Training Objective

Upon completion of this training unit the learner must be familiar with the basic skills required to observe the patient's symptoms, condition, changes in condition, response to therapy, and reaction to hospital environment; to communicate with the patient about his illness, therapy, condition, care, medications, treatments, procedures, examinations, tests, needs, and problems; to report to his supervisors about the patient's condition, changes in condition, his response to care, treatments, medications, procedures, examinations, tests, and routines; to prepare and transmit official written reports and maintain official records; and to teach the patient basic skills for giving his own care and for health maintenance.

The learner must be able to accomplish the foregoing with direct, indirect, or selective supervision and without assistance. He must be able to observe thoroughly, to communicate so that the receivers obtain the correct information in the proper form and to teach so as to provide effective learning. These basic skills must improve with experience.

Good observations provide essential information about the patient; good communication skills control future actions and behavior; and good patient teaching provides the required knowledge and skills for self care and health maintenance.

Knowledge and Skills

1. Response of special senses to stimuli
2. Significance of observation in emergency and routine patient care
3. Communications--working definition, objectives, process, types, factors influencing verbal and written communication effectiveness, non-verbal communication, reports and records.
4. Purpose of patient teaching
5. Plan for teaching

Instructional Strategies

1. Slides, filmstrips, film, videotapes, and/or mediated programmed instruction (individual or group) on purpose, process, techniques of verbal and non-verbal communication; purpose of and skill in preparing written communications; presentation of patient signs, symptoms, and conditions involving sensory perceptions; purpose, procedures, and techniques for simplified teaching of patients.
2. Hardcover programmed instruction
3. Lecture
4. Discussion
5. Demonstration
6. Role playing
7. Practice in simulated patient care unit
8. Study assignments
9. Written exercises

Training Aids

1. Filmstrips/films/videotapes
2. Mediated programmed instruction
3. Hardcover programmed instruction
4. Slides
5. Chalk board
6. Newsprint chart
7. Tape recorder
8. Equipment and supplies
9. Instructor's guide

10. Student syllabus

11. References

Examination Modes

1. Response in classroom
2. Paper and pencil test
3. Rating on performance in simulated practice
4. Rating on performance in work situation (feedback)
5. Oral quiz on knowledge related to performance in simulated practice and/or work situation (feedback)
6. Case studies

Training Time

5:00 hours didactic

6:00 hours supervised practice

LEARNING MODULE ID1
BASIC OBSERVATION SKILLS ESSENTIAL TO PATIENT CARE

Tasks

- 130023 Observe for/report symptoms of cardiac arrest
- 130026 Observe for/report symptoms of delirium tremens
- 130027 Observe for/report symptoms of diarrhea
- 130034 Observe for/report symptoms of food poisoning
- 130036 Observe for/report symptoms of drug/chemical ingestion (poisoning)
- 130039 Observe for/report symptoms of hangovers
- 130040 Observe for/report symptoms of head colds
- 130046 Observe for/report symptoms of influenza
- 130048 Observe for/report symptoms of intestinal worms
- 130051 Observe for/report symptoms of malaria
- 130059 Observe for/report symptoms of shock
- 130062 Observe for/report symptoms of sinus blockage
- 130097 Observe/report symptoms of side effects to treatment/medication
- 130099 Observe patient for/report and describe abnormal respirations
- 130100 Observe patient for signs of chilling
- 130045 Observe and describe parent-child interaction
- 130047 Observe children for and describe symptoms of hyperactivity
- 130057 Observe patient's behavior patterns
- 130255 Observe for/report symptoms of insulin reaction
- 130258 Observe for/report symptoms of urinary tract infection
- 130259 Observe for/report symptoms of wound infection
- 130260 Observe for/report symptoms of dehydration
- 130271 Observe for/report symptoms of external hemorrhage
- 130273 Observe for/report symptoms of aspiration
- 130365 Observe for/report symptoms of cellulitis
- 130367 Observe for/report symptoms of infection of oral mucosa, e.g., thrush
- 130264 Observe for/report or describe symptoms of irritability, restlessness, apprehension
- 130374 Observe patient's general emotional condition, e.g., facial and eye expressions, quality of voice

- 130377 Observe patient's orientation to time, place, person
- 130378 Observe patient's eating patterns
- 130379 Observe patient's physical movement, e.g., muscular condition, posture, balance
- 130380 Observe patient's ability to receive or express spoken, written or printed communication
- 130381 Observe patient's general appearance, e.g., dress, grooming
- 130382 Observe/record patient's physical/emotional response to treatment/diagnostic procedures
- 130388 Observe/record or describe characteristics of urine or feces or vomitus or regurgitation
- 130389 Observe for/report patient's level of physical activity, e.g., lethargy, hyperactivity
- 130393 Observe/report patient's level of consciousness
- 130405 Observe for/report characteristics of cough
- 130423 Observe/record or describe characteristics of drainage from internal body organs
- 130424 Observe/record or describe characteristics of drainage from incisions/wounds
- 130425 Observe/record or describe characteristics of sputum, mucus
- 130426 Observe/record or describe characteristics of drainage from eyes/ears
- 130433 Observe patient's sleeping patterns
- 130435 Observe/report patient's muscle tone, e.g., rigid, flaccid, spastic, spasms
- 130437 Observe/describe or report characteristics of convulsions/seizures
- 130438 Observe for/report symptoms of inebriation (drunkenness)
- 130494 Observe for/report or describe visual disturbances, e.g., blurred, double, mirror, tunnel
- 130495 Observe for/describe hearing disturbances, e.g., ringing, hearing loss
- 130496 Observe for/report tendencies toward suicidal behavior
- 130560 Observe for/report decreased urine output of patients susceptible to renal shutdown
- 130564 Observe patient's general mental attitude
- 130574 Observe for patient's need to ventilate feelings
- 130578 Observe for effect of visitors on patient
- 130588 Observe for/describe or report characteristics of twitching, tremors, tics

- 130589 Observe for/report symptoms of drug abuse, e.g., acid, speed
130590 Observe for/report symptoms of drug dependency, e.g., frequent
request for pain medication
130636 Observe for/report symptoms of hypotension/hypertension

Performance Objective (Stimulus)

When assigned by the doctor, nurse, or senior corpsman/technician to give care to a patient and to make patient rounds and when a patient presents signs and symptoms of illness and/or injury.

Performance Objective (Behavior)

The corpsman/technician will observe and describe the signs, symptoms, and condition of the patient as seen, heard, smelled, tasted, or touched.

Performance Objective (Conditions)

With indirect or selective supervision and without assistance.

Performance Objective (Criteria)

In accordance with his sense responses to the given stimuli.

Performance Objective (Consequence)

Description of signs, symptoms, and condition of patient.

Performance Objective (Next Action)

Report to supervisory personnel.

Knowledge and Skills

1. Response of senses to given stimuli
 - a. Sight--what is seen, e.g., blood, pus, swelling, position
--behavior, e.g., non-responsive, thrashing about
 - b. Smell--odor, e.g., like apples, fetid
 - c. Taste--what is tasted, e.g., solution at bedside tastes bitter,
like whiskey
 - d. Sound--what is heard, e.g., gurgling in throat, rattling in chest
 - e. Touch--what is felt, e.g., hardness, heat, cold, clammy
--extent, what area affected

2. Significance of observations in emergency and routine care

Instructional Strategies

1. Slides, filmstrips, films, videotapes, and/or mediated programmed instruction (individual or group) on presentation of patient signs, symptoms, and conditions that would involve use of all sensory perception, e.g., diabetic coma, shock, extensive local infection.
2. Hardcover programmed instruction
3. Lecture
4. Discussion
5. Practice in simulated patient care unit
6. Study assignments
7. Written exercises

Training Aids

1. Filmstrips/films/videotapes
2. Mediated programmed instruction
3. Hardcover programmed instruction
4. Slides
5. Wall charts
6. Instructor's guide
7. Student syllabus
8. References

Examination Modes

1. Response in classroom
2. Paper and pencil test
3. Rating on performance in simulated practice
4. Rating on performance in work situation (feedback)
5. Oral quiz on knowledge related to performance in simulated practice and/or work situation (feedback)
6. Case studies

Training Time

2:00 hours didactic

2:00 hours supervised practice

LEARNING MODULE ID2
BASIC COMMUNICATION SKILLS ESSENTIAL TO PATIENT CARE

Tasks

- 130023 Observe for/report symptoms of cardiac arrest
- 130026 Observe for/report symptoms of delirium tremens
- 130027 Observe for/report symptoms of diarrhea
- 130034 Observe for/report symptoms of food poisoning
- 130036 Observe for/report symptoms of drug/chemical ingestion (poisoning)
- 130039 Observe for/report symptoms of hangovers
- 130040 Observe for/report symptoms of head colds
- 130046 Observe for/report symptoms of influenza
- 130048 Observe for/report symptoms of intestinal worms
- 130051 Observe for/report symptoms of malaria
- 130059 Observe for/report symptoms of shock
- 130062 Observe for/report symptoms of sinus blockage
- 130097 Observe/report symptoms of side effects to treatment/medication
- 130099 Observe patient for/report and describe abnormal respirations
- 130045 Observe and describe parent-child interaction
- 130047 Observe children for and describe symptoms of hyperactivity
- 130255 Observe for/report symptoms of insulin reaction
- 130258 Observe for/report symptoms of urinary tract infection
- 130259 Observe for/report symptoms of wound infection
- 130260 Observe for/report symptoms of dehydration
- 130271 Observe for/report symptoms of external hemorrhage
- 130273 Observe for/report symptoms of aspiration
- 130365 Observe for/report symptoms of cellulitis
- 130367 Observe for/report symptoms of infection of oral mucosa, e.g., thrush
- 130264 Observe for/report or describe symptoms of irritability, restlessness, apprehension
- 130380 Observe patient's ability to receive or express spoken, written or printed communication
- 130388 Observe/record or describe characteristics of urine or feces or vomitus or regurgitation

- 130389 Observe for/report patient's level of physical activity, e.g., lethargy, hyperactivity
- 130393 Observe/report patient's level of consciousness
- 130405 Observe for/report characteristics of cough
- 130423 Observe/record or describe characteristics of drainage from internal body organs
- 130424 Observe/record or describe characteristics of drainage from incisions/wounds
- 130425 Observe/record or describe characteristics of sputum, mucus
- 130426 Observe/record or describe characteristics of drainage from eyes/ears
- 130425 Observe/report patient's muscle tone, e.g., rigid, flaccid, spastic, spasms
- 130437 Observe/describe or report characteristics of convulsions/seizures
- 130438 Observe for/report symptoms of inebriation (drunkenness)
- 130494 Observe for/report or describe visual disturbances, e.g., blurred, double, mirror, tunnel
- 130495 Observe for/describe hearing disturbances, e.g., ringing, hearing loss
- 130496 Observe for/report tendencies toward suicidal behavior
- 130588 Observe for/describe or report characteristics of twitching, tremors, tics
- 130589 Observe for/report symptoms of drug abuse, e.g., acid, speed
- 130590 Observe for/report symptoms of drug dependency, e.g., frequent request for pain medication
- 130636 Observe for/report symptoms of hypotension/hypertension
- 120006 Explain audiogram test procedures to patient
- 120008 Explain/answer questions about doctor's instructions to patient/family
- 120009 Explain ECG procedure to patient
- 120010 Explain/answer patient's questions regarding examination/test/treatment procedures
- 120012 Explain physiological basis for therapy/treatment to patient/family
- 120016 Explain/answer questions about treatment procedure via telephone
- 120017 Teach patient medication storage requirements, e.g., refrigeration, expiration date
- 120018 Explain X-ray procedures to patient
- 120046 Reassure/calm apprehensive (anxious) patient
- 120050 Teach patient/family side effects of medication, e.g., drowsiness, urine discoloration

- 120052 Explain/answer patient/family questions about medications, e.g., purpose, dose, schedule
- 120063 Inform patient/family where to obtain medical supplies
- 120070 Explain paracentesis procedure to patient
- 120071 Explain lumbar puncture procedures to patient
- 120072 Explain thoracentesis procedures to patient
- 120080 Inform patient of procedures required prior to/during examination/test/treatment
- 120082 Answer patient inquiries regarding nonprescription drugs
- 120083 Counsel patient/family on when and where to seek medical care
- 120085 Reassure apprehensive parents of pediatric patient
- 120088 Reassure/calm children for examination or treatment
- 120090 Explain minor surgical procedure/operation to patient/family
- 120091 Explain/answer patient's questions regarding symptoms/disease/treatment
- 120097 Explain procedures for pulmonary function tests to patient
- 120100 Explain/answer questions about venereal disease, e.g., prevention, symptoms
- 120104 Recommend/give patient/family supplementary health education pamphlets or books
- 120118 Inform patient/family of symptoms of intolerance/overdose to medication, e.g., bleeding gums, coma
- 120120 Inform patient/family of recreational activities in the community, e.g., senior citizen club
- 120122 Listen to patient/family discuss their personal problems
- 120123 Listen to patient/family express feelings on death
- 120124 Comfort the dying patient or his family
- 120129 Teach patient/family administration of injection
- 120131 Ask/instruct patient to collect specimen
- 120133 Explain to patient/family post-op procedures/care for radical surgery
- 120135 Explain schedules to patients/families, i.e., time to and from O.R., appointments
- 120142 Explain to patient how/where to apply for social services
- 120268 Suggest books (fiction/non-fiction) to patient for therapeutic purposes
- 120269 Encourage patient to participate in social activities, e.g., parties, sports
- 120271 Explain isolation procedures to patient/family
- 120275 Orient patient to time, place, person

- 120276 Explain/answer patients' questions about behavior, treatment of another patient
- 120292 Direct patient to outlets for release of tension or aggression, e.g., sports, other physical activities
- 130005 Record/tally fluid intake and output
- 130400 Report changes or imbalances in intake and output
- 150006 Consult doctor or nurse to obtain information/advice on patient care
- 150011 Confer with chaplain to discuss patient/family needs/problems
- 150013 Make suggestion regarding patient care, e.g., need of medication, treatment
- 150017 Recommend need for specialty consult/referral
- 150019 Recommend need for paramedical consult or referral, e.g., social worker, O.T., P.T.
- 150023 Recommend psychological approach to use with patient
- 150028 Prepare a care plan for patient
- 150031 Confer with corpsman to discuss patient treatment/progress/problem
- 150035 Give report on changes/special care/treatment/tests for patient
- 150036 Inform doctor/nurse of patient's condition, e.g., description of injury, symptoms, response
- 150048 Refer patient to doctor for treatment
- 150049 Refer patient to nurse for treatment
- 150051 Review doctor's orders and instructions with doctor
- 150054 Obtain clarification of conflicting doctor's orders
- 150063 Talk with patient to ascertain needs/problems
- 150064 Write nursing notes
- 150069 Give/receive verbal reports about patient
- 150073 Notify medical personnel of treatment needs for patient
- 150078 Ask patient/check chart for contraindication for treatment, procedure, test
- 150082 Suggest changes in nursing care plan for patient
- 150085 Modify patient care according to patient's response/need, e.g., physical activity
- 150088 Follow up patient to determine if needed services were obtained
- 150089 Refer patient to legal resources
- 150092 Confer with paramedical personnel to discuss patient progress/problems, e.g., O.T., P.T., social worker

- 150107 Write orders in patient's chart for doctor's counter signature
- 150108 Develop communication techniques for patient with communication problem, e.g., cards
- 150144 Elicit information to ascertain patient's understanding/acceptance of illness/treatment
- 240093 Answer personnel inquiries regarding mixing/administering drugs
- 240127 Answer inquiries regarding drug reaction
- 250039 Plot reading/values on rectilinear graph paper
- 310051 Suggest topics for classes/conferences
- 320034 Consult with staff to design/amend/update procedures/techniques
- 321133 Request/recommend additional personnel when required
- 330207 Inform doctor of any contraindications to study
- 320223 Recommend disciplinary action for personnel as required
- 320230 Review suggestions and complaints from personnel
- 320338 Make recommendations on purchase/replacement of equipment/supplies
- 320366 Prepare ward report
- 330008 Allocate lockers
- 330014 Assign work to patients
- 330048 Draft ward/clinic accident/incident reports, i.e., work injury reports for patients or staff
- 330056 Inform hospital authorities of patient's condition
- 330103 Maintain KARDEX file/system
- 330111 Maintain daily records on patient procedures/examinations performed
- 330143 Place special treatment tags over/on beds, e.g., fasting, force fluids
- 330407 Record administration of medication on patient health record
- 330423 Prepare leave request forms
- 330484 Prepare patient liberty list
- 330467 Refer onward to the proper personnel queries from civilian associations/ individuals

Performance Objective (Stimulus)

When communicating with patients and staff members.

Performance Objective (Behavior)

The corpsman/technician will suggest, request, recommend, and direct relative to the required actions of the patient to his therapy, treatment, and role as

a patient; give, explain, and clarify information to the patient relative to his diagnosis, therapy, condition, care, treatments, procedures, tests, and examinations; elicit from him by questions and discussions his understanding and acceptance of his illness, treatment, and patient role; verbally and non-verbally calm, reassure, encourage, and comfort the patient when he is apprehensive, anxious, discouraged, worried, and depressed; and when in doubt about providing the needed information and emotional support to the patient, refer him to appropriate supervisory personnel. The corpsman/technician will report verbally to his supervisor patient needs, condition, change in condition, and treatment, test and examination given, and the patient's response to them; consult with supervisor as to means for meeting patient's needs and requirements and accomplishing his tasks; confer with other staff members on ward and in other departments about patient's needs and requirements and how they may be met; and make suggestions and recommendations for patient care and for hospital activities needed in support of this care. He will prepare official records, such as nursing notes and nursing care plan; official requests, such as leave and liberty requests; and official reports, such as ward and accident reports.

Performance Objective (Conditions)

With indirect or selective supervision and without assistance.

Performance Objective (Criteria)

Using effective verbal, non-verbal, and written communication skills.

Performance Objective (Consequence)

Attainment of an understanding between corpsman/technician and patient/or staff members which controls future actions and behavior.

Knowledge and Skills

1. Definition of communication: attaining an understanding between individuals or groups of individuals which controls future actions and behavior.
2. Objectives of communication--comprehension as evidenced by action and/or feedback.

3. Communication process--initiating, transmitting, receiving
4. Types of communication--written, verbal, non-verbal
5. Techniques of verbal communication--talking, listening, observing, questioning for information and redirection of conversation, encouraging verbalization, respect for individual dignity and privacy.
6. Effectiveness of verbal communication--dependent on perceived reliability of the source; receiver's interpretation and understanding; climate in which communication is transmitted; conciseness, clarity, completeness of communication.
7. Effectiveness of written communication--dependent on format, logical presentation, on being factual, clear, concise, complete, presented at reader's level of understanding.
8. Non-verbal communication--expressed by body action, facial expression, physical contact.
9. Reports--verbal or written communication is concise, complete, clear, factually and logically presented, such as verbal report on patient's symptoms and written report on the patient's condition to the nursing office.
10. Records--written, permanent, reports may become records, such as an accident report.

Instructional Strategies

1. Slides, filmstrips, films, videotapes, and/or mediated programmed instruction (individual or group) on purpose, process, techniques of verbal and non-verbal communication; purpose of and skill in preparing written communications.
2. Hardcover programmed instruction
3. Lecture
4. Discussion
5. Demonstration
6. Role playing
7. Study assignments
8. Written exercises

Training Aids

1. Filmstrips/films/videotapes
2. Mediated programmed instruction
3. Hardcover programmed instruction

4. Chalk board
5. Tape recorder
6. Instructor's guide
7. Student syllabus
8. References

Examination Modes

1. Response in classroom
2. Paper and pencil test
3. Rating on performance in simulated practice
4. Rating on performance in work situation (feedback)
5. Oral quiz on knowledge related to performance in simulated practice and/or work situation (feedback)

Training Time

- 2:00 hours didactic
- 2:30 hours supervised practice

LEARNING MODULE 1D3
FUNDAMENTALS IN TEACHING THE PATIENT

Tasks

- 120038 Teach breathing exercises
- 120101 Teach patient self-administration of medications (other than injections)
- 120107 Teach patient/family transfer techniques, e.g., bed to chair, chair to
commode
- 120200 Instruct patient on pre and post spinal anesthesia procedures
- 120316 Teach patient to cough and deep breathe
- 319025 Instruct on personal hygiene
- 120061 Instruct patient/family on post immunization care and schedule
- 120102 Instruct patient in preventive care of finger and toenail abnormalities
- 120115 Teach patient/family nursing care procedures, e.g., dressing change,
cast care
- 120129 Teach patient/family administration of injection
- 315009 Instruct non-medical personnel in health subjects
- 319024 Lecture/orient personnel on VD and other social diseases

Performance Objective (Stimulus)

When assigned by the doctor, nurse, or senior corpsman/technician to teach or instruct patients about their illness and self-care and when a patient needs to know about his illness and self-care.

Performance Objective (Behavior)

The corpsman/technician will determine why the patient needs to know, what he needs to know, how to teach him, where to teach him and when to teach him; give the needed instruction, using appropriate training aids; and test the patient's learning by feedback.

Performance Objective (Conditions)

With supervision and without assistance.

Performance Objective (Criteria)

In accordance with established standard teaching practices.

Performance Objective (Consequence)

Effective learning on the part of the patient.

Performance Objective (Next Action)

Record on patient's record and report to supervisor if indicated.

Knowledge and Skills

1. Purpose of patient teaching
2. Types of teaching--formal and informal
3. The teacher and the learner
4. Lesson plan--purpose, objectives, content, methodology for instruction, including training aids, place to teach the patient, and when to teach him.
5. Purpose--why is patient being taught
6. Objectives--what does he need to know
7. Method--lecture (telling); demonstrating (showing); discussion (questioning/answering)
8. Training aids--simple set of printed instructions, equipment and supplies to be used by the patient, pictures or diagrams, pamphlets or brochures, best to use what patient can keep for reference or will be using.
9. Place to teach--quiet, appropriate to what is being taught, e.g., taking oral medications may be taught at bedside; care of colostomy should be taught in bathroom where appropriate facilities are available.
10. Time for teaching--prior to patient's need to know and/or do and in time for practice prior to leaving hospital.
11. Feedback--questioning patient when knowledge such as symptoms of diabetic coma insulin shock are subject; practice prior to discharge such as giving insulin.

Instructional Strategies

1. Slides, filmstrips, films, videotapes, and/or mediated programmed instruction (individual or group) on purpose, procedure, and techniques for simplified teaching of patients.
2. Hardcover programmed instruction
3. Lecture

5. Discussion
6. Demonstration
7. Practice in simulated patient care unit
8. Study assignments
9. Written exercises

Training Aids

1. Filmstrips/films/videotapes
2. Mediated programmed instruction
3. Hardcover programmed instruction
4. Slides
5. Chalk board
6. Newsprint chart
7. Equipment and supplies
8. Instructor's guide
9. Student syllabus
10. References

Examination Modes

1. Response in classroom
2. Paper and pencil test
3. Rating on performance in simulated practice
4. Rating on performance in work situation (feedback)
5. Oral quiz on knowledge related to performance in simulated practice and/or work situation (feedback)

Training Time

- 1:00 hour didactic
- 1:30 hours supervised practice

TRAINING UNIT IE
GIVING GENERAL PATIENT CARE

Learning Modules

- IE1. The Patient's Unit: Preparation and Maintenance
- IE2. Patient Care: Preliminary Steps
- IE3. Patient Care: Interaction During Care
- IE4. Patient Care: Reporting and Recording
- IE5. Patient Care: Washing and Scrubbing of the Hands
- IE6. Patient Care: Moving and Positioning the Patient
- IE7. Patient Care: Moving and Transporting Patient
- IE8. Patient Care: Clothing the Patient and Monitoring Apparel
- IE9. Patient Care: Making an Occupied Bed
- IE10. Patient Care: Oral Hygiene and Mouth Irrigation
- IE11. Patient Care: Nail and Hair Care
- IE12. Patient Care: Bathing the Patient
- IE13. Patient Care: Diets and Nutrition
- IE14. Patient Care: Serving Meals and Nourishment
- IE15. Patient Care: Assisting the Patient to Eat and Feeding the Patient
- IE16. Patient Care: Assisting the Patient with Elimination
- IE17. Patient Care: Rest and Sleep
- IE18. Patient Care: Activity and Exercise
- IE19. Patient Care: Observation of Patient Behavior
- IE20. Patient Care: Safety and Restraint
- IE21. Patient Care: Recreation
- IE22. Patient Care: Patients with Communication Problems
- IE23. Patient Care: Measure and Weigh Patients
- IE24. Patient Care: Security of Patient's Property
- IE25. Patient Care: Very Seriously Ill and Dying Patients
- IE26. Post Mortem Care

Training Objective

Upon completion of this training unit, the learner must be able to verify the care to be given and the identity of the patient to whom it is to be given;

determine any contraindications for giving the care; inform the patient about the care to be given and, if necessary, explain the procedure to him and answer his questions about it; assess the patient's capability to give his own care and encourage him to assist in giving or give it; communicate with the patient about his needs, problems, and complaints; observe the patient's symptoms and his physical and emotional response to care; instruct the patient on relevant personal hygiene; report changes in the patient's condition and special care given to him; make suggestions regarding changes in care; initiate and implement changes in the patient care according to need and write nursing notes.

Also, the learner must be able to prepare and maintain the patient's unit; measure and weigh patients and move, position and transport them; make an occupied bed; give oral hygiene, mouth irrigations, and nail and hair care, and baths to the patient and clothe him; serve meals and nourishment, assist the patient in eating or feed him; observe the patient's eating habits, help him select menu and teach him about diets and their relation to his health; assist patients in the use of bedpans, urinals and commode chairs; change incontinent patients; make patient comfortable for rest and sleep and provide environment conducive to rest or sleep; observe the level of the patient's physical activity and his tolerance for activity and exercise; observe the patient's behavior for deviation from the normal and, if necessary, restrain him; provide recreation and information about available recreation activities; develop communication techniques for communicating with patients with hearing, speech and/or sight loss and non-English speaking; provide security for patient's property; give care to the very seriously ill and dying patient; and give post mortem care.

The learner must be able to accomplish the foregoing usually with indirect or selective supervision and with or without an assistant, depending upon the condition of the patient.

He must be able to perform according to established standard procedures, policies, rules, regulations and accepted common practice. These actions

will provide the patient with personal hygiene, comfort, and safety, all of which are essential to his daily living and recovery from illness.

Knowledge and Skills

1. Anatomy and physiology relevant to the care being given
2. Observation techniques for assessing patient's needs and condition
3. Communication techniques for giving information to and eliciting information from the patient
4. Communication techniques for informing staff about patient
5. Instructional techniques for informing the patient of his disease, therapy, and treatment as related to care
6. Procedures for verification of care to be given and patient to whom it is to be given
7. Records used for recording patient care and procedures for recording
8. Purpose, objectives, procedures, and techniques for preparing and maintaining the patient's unit; hand washing and scrubbing; measuring and weighing patient; moving, positioning, and transporting patients; making an unoccupied and an occupied bed; giving oral hygiene and mouth irrigations; bathing patient and giving nail and hair care; serving meals and nourishment and assisting patient to eat or feeding him; assisting patient with bedpans and urinals and changing an incontinent patient; making a patient comfortable for rest and sleep and providing an environment conducive for rest and sleep; assessing a patient's tolerance for exercise and activity and observing his behavior; assuring safety for the patient and security for his property; restraining a patient; encouraging a patient's participation in recreational activities; developing communication methods for patients with hearing, sight, and/or speech loss and non-English speaking patients; care of the very seriously ill and dying patient; and post mortem care.
9. Body mechanics for lifting
10. Operations of patient care equipment
11. Commonly transmitted disease and infections through personal contact
12. Weight as related to body structure and common abnormalities
13. Nutrition-food functions and composition, caloric values and balanced diet, classification of diets and diets in disease
14. Pressure points on body as related to body position
15. Criteria for evaluating patient's condition
16. Policies, rules, regulations, routines pertaining to patient and patient care

Instructional Strategies

1. Pretest and/or review on observation, communication, and teaching skills; anatomy and physiology of muscular-skeletal, digestive and nervous systems, urinary tract and skin
2. Slides, filmstrip, film, videotape and/or mediated programmed instruction (individual or group) for each module in the training unit
3. Hardcover programmed instruction
4. Lecture
5. Discussion
6. Demonstration
7. Role-playing
8. Practice in simulated patient care unit
9. Practice in work situation
10. Study assignments
11. Written exercises

Training Aids

1. Filmstrip/films/videotape
2. Mediated programmed instruction
3. Hardcover programmed instruction
4. Slides
5. Wall charts
6. Chalk board
7. Felt board
8. Newsprint chart
9. Anatomical models
10. Equipment and supplies
11. Instructor's guide
12. Student syllabus
13. References

Examination Modes

1. Response in classroom
2. Paper and pencil test

3. Rating on performance in simulated practice
4. Rating on performance in work situation (feedback)
5. Oral quiz on knowledge related to performance in simulated practice and/or work situation (feedback)

Training Time

20:45 hours didactic

15:30 hours supervised practice

LEARNING MODULE 1E1
THE PATIENT'S UNIT: PREPARATION AND MAINTENANCE

Tasks

- 340036 Clean and arrange bedside units
- 150046 Arrange room/unit for individual patient needs; e.g., blind, bedridden, post operative
- _____ Make an unoccupied (standing) bed
- 340037 Change linens; e.g., bed, examination table, bedside curtains
- 110030 Issue hospital comforts to patient; e.g., Kleenex, soap, toothpaste, Red Cross supplies
- 340116 Perform routine safety inspections

Performance Objective (Stimulus)

When assigned by the doctor, nurse, or senior corpsman/technician to clean and arrange the patient's unit.

Performance Objective (Behavior)

The corpsman/technician, when the patient is discharged or transferred from the ward unit, will remove the bedside curtains and all linen from the bed and bedside locker and remove all patient equipment and supplies such as bedpan, face basin, emesis basin, and unused tissues; scrub all furniture in the unit; make the bed with clean linen; replace the bedside curtains; place clean bedpan, emesis basin and wash basin in the locker; place clean pajamas, robe, slippers, towel and wash cloth in the locker; arrange neatly and conveniently the furniture in the unit and check lamps and other equipment for safety. When caring for a patient, the corpsman/technician will damp dust all furniture, remove all soiled linen and leave the patient's unit equipped, convenient and neat, including a fresh pitcher of water and drinking glass and personal supplies such as toothpaste, soap and tissues.

Performance Objective (Conditions)

With indirect supervision and without assistance

Performance Objective (Criteria)

In accordance with established standard procedures, techniques, and routines

Performance Objective (Consequence)

Patient care unit ready for a new admission and is neat and clean for the patient occupying it

Performance Objective (Next Action)

Continue with assignment

Knowledge and Skills

1. Purpose and objectives of clean and neat patient unit
2. Equipment and supplies in a patient unit
3. Procedure, techniques, and routines for intermittent and terminal cleaning and tidying of patient's unit; conveniently arranging it; and making an unoccupied bed

Instructional Strategies

1. Slides, filmstrip, film, videotape and/or mediated programmed instruction (individual or group) on: purpose, procedures, techniques, and routines for stripping unit of discharged or transferred patient; cleaning the unit; making an unoccupied bed; refurnishing the unit with required equipment and supplies; and arranging it neatly and conveniently; and for cleaning and tidying an occupied unit and arranging it for the patient's convenience.
2. Hardcover programmed instruction
3. Lecture
4. Discussion
5. Demonstration
6. Practice in simulated patient care unit
7. Study assignments
8. Written exercises

Training Aids

1. Filmstrip/films/videotape
2. Mediated programmed instruction

3. Hardcover programmed instruction
4. Slides
5. Chalk board
6. Equipment and supplies
7. Instructor's guide
8. Student syllabus
9. References

Examination Modes

1. Response in classroom
2. Paper and pencil test
3. Rating on performance in simulated practice
4. Rating on performance in work situation (feedback)
5. Oral quiz on knowledge related to performance in simulated practice and work situation (feedback)

Training Time

- 1:00 hour didactic
- 0:45 hour supervised practice

LEARNING MODULE IE2
PATIENT CARE: PRELIMINARY STEPS

Tasks

- 320328 Cross check medication and treatment card with KARDEX and doctor's orders
- 110063 Verify identification of the patient, e.g., treatment, medication, examination
- 120080 Inform patient of procedure prior to/during examination/test/treatment
- 150078 Ask patient/check chart for contraindications for treatment/procedure/test
- 120010 Explain/answer patient's questions regarding examination/test/treatment/procedure
- 120046 Reassure/calm apprehensive/anxious patient
- _____ Assess the patient's capability to give his own care/medication/treatment

Performance Objective (Stimulus)

When care is needed by the patient or when assigned by the senior corpsman/technician, nurse, or physician to give or to assist with giving the care.

Performance Objective (Behavior)

The corpsman/technician will verify the care to be given and the identity of the patient who is to receive it; determine any contraindications for giving the care; inform the patient about the care to be given and, if necessary, explain the procedure to him, answer his questions, and reassure him; and assess the patient's capability to give his own care.

Performance Objective (Conditions)

With selective supervision and without assistance using the nursing assessment, the nursing care plan, the medication and treatment card, the doctor's orders, the patient's bedside chart and identification bracelet, and information from the patient.

Performance Objective (Criteria)

In accordance with established standard procedures, techniques, and routines.

Performance Objective (Consequence)

Accurate identification of the patient care to be given and any contraindications to the care; accurate assessment of patient's condition and his capability to help himself; and the patient has understanding of the care he is to receive.

Performance Objective (Next Action)

To collect equipment and supplies for giving the care.

Knowledge and Skills

1. Purpose and objectives of preliminary steps to care
2. Procedures for verification of needed/required care and contraindications to it
3. Procedures for verification of patient's identity
4. Patient's disease, therapy and condition as related to care
5. Records--nursing assessments, nursing care plan, medication and treatment cards, doctor's orders
6. Patient's bedside card and identification bracelet
7. Observation techniques for assessing patient's needs and condition
8. Communication techniques for giving information to and eliciting information from the patient

Instructional Strategies

1. Pretest and/or review on observation and communication skills
2. Slides, filmstrip, film, videotape and/or mediated programmed instruction, group or individual, on purpose, procedure, techniques, and routines for verifying orders for care, treatments, examinations, and tests; determining contraindications; providing information to the patient about care, treatments, examinations, and test; reassuring the patient and assessing his capability to help himself.
3. Hardcover programmed instruction
4. Lecture
5. Discussion
6. Demonstration
7. Practice in simulated patient care units
8. Study assignments
9. Written exercises

Training Aids

1. Filmstrip/films/videotape
2. Mediated programmed instruction
3. Hardcover programmed instruction
4. Slides
5. Chalk board
6. Nursing assessments, nursing care plan, medication and treatment cards, doctors orders, patient's identification bracelet and bedside card
7. Medication board
8. Instructor's guide
9. Student syllabus
10. References

Examination Modes

1. Response in classroom
2. Paper and pencil test
3. Rating on performance in simulated practice
4. Rating on performance in work situation (feedback)
5. Oral quiz on knowledge related to performance in simulated practice and work situation (feedback)

Training Time

- 1:30 hours didactic
- 1:00 hours supervised practice

LEARNING MODULE IE3

PATIENT CARE: INTERACTION DURING CARE

Tasks

- 150063 Talk with patient to ascertain needs/problems
- 130436 Evaluate patient's complaints/symptoms of pain
- 120293 Progressively lessen patient's dependency on medical personnel
- 120036 Encourage patient's independence and involvement in self care
- 319025 Instruct patient on personal hygiene
- 130382 Observe/record patient's physical/emotional response to treatment/
diagnostic procedures

Performance Objective (Stimulus)

When giving care to the patient.

Performance Objective (Behavior)

The corpsman/technician will communicate with the patient about his needs, problems, and complaints; observe the patient's symptoms and his physical and emotional response to care; encourage the patient's involvement in his own care lessening dependence on others and instruct him on relevant personal hygiene.

Performance Objective (Conditions)

Without supervision or assistance.

Performance Objective (Criteria)

In accordance with correct and appropriate communication, observation, and instructional skills.

Performance Objective (Consequence)

More knowledgeable and less anxious patient with increased willingness to assist in or give his own care.

Performance Objective (Next Action)

Proceed with the patient's care.

Knowledge and Skills

1. Purpose and objectives of interaction with patient during care
2. Patient's disease, therapy and condition as related to care
3. Observation techniques for assessing patient's needs and condition
4. Communication techniques for giving information to and eliciting information from patient
5. Instructional techniques for teaching patient
6. Techniques for increasing patient's self-sufficiency

Instructional Strategies

1. Pretest and/or review on observation, communication, and instructional skills.
2. Slides, filmstrip, film, videotape and/or mediated programmed instruction (individual or group) on specific observation and communication relative to a patient's condition and purpose.
3. Lecture
4. Discussion
5. Demonstration
6. Practice in simulated patient care unit
7. Study assignments
8. Written exercises

Training Aids (as required for review)

1. Filmstrip/films/videotape
2. Mediated programmed instruction
3. Hardcover programmed instruction
4. Slides
5. Chalk board
6. Newsprint chart
7. Instructor's guide
8. Student syllabus
9. References

Examination Modes

1. Response in classroom
2. Paper and pencil test
3. Rating on performance in simulated practice
4. Rating on performance in work situation (feedback)
5. Oral quiz on knowledge related to performance in simulated practice and work situation (feedback)

Training Time

0:30 hour didactic

0:30 hour supervised practice

LEARNING MODULE IE4
PATIENT CARE: REPORTING AND RECORDING

Tasks

- 150093 Determine need to notify doctor/nurse about patient's condition
- 150036 Inform doctor/nurse about patient's condition
- 150035 Give report on changes/special care/treatments/tests for patient
- 150013 Make suggestions regarding patient care
- 150082 Suggest changes in nursing care plan for patient
- 150102 Initiate and implement changes in patient's nursing care plan
- 150085 Modify patient care plan according to patient's response and needs, e.g., physical activity
- 150064 Write nursing notes

Performance Objective (Stimulus)

When indicated during the giving of patient care and when care is completed.

Performance Objective (Behavior)

The corpsman/technician will report changes in the patient's condition and special care given; make suggestions regarding patient's care; suggest changes in the nursing care plan and modify the plan according to the changes made; and write nursing notes.

Performance Objective (Conditions)

With selective supervision and without assistance, using appropriate communication skills, nursing care plan and nursing notes.

Performance Objective (Criteria)

Appropriate and accurate reporting and recording in accordance with established standard procedures, techniques, and practices.

Performance Objective (Consequence)

Current and accurate reporting and recording of patient care.

Performance Objective (Next Action)

The next action is a follow-up on patient's comfort and condition.

Knowledge and Skills

1. Purpose and objectives of reporting and recording patient care
2. Criteria for determining what needs to be reported to supervisor and when
3. Communication skills for reporting and suggesting change
4. Patient's disease, therapy, condition as related to care
5. Patient care plan
6. Procedure for modifying patient care plan
7. Nursing notes
8. Procedure for recording on nursing notes

Instructional Strategies

1. Pretest and/or review on nursing assessment; nursing care plan; medication and treatment card; doctor's orders; routine for identifying patient; communication skills.
2. Slides, filmstrip, film, videotape and/or mediated programmed instruction (individual or group) on purpose, procedures, techniques, and routines for recording on nursing notes, modifying nursing care plan, and reporting to supervisor about the patient.
3. Lecture
4. Discussion
5. Demonstration
6. Practice in simulated patient care unit
7. Study assignments
8. Written exercises

Training Aids

1. Filmstrip/films/videotape
2. Mediated programmed instruction
3. Hardcover programmed instruction
4. Slides
5. Chalk board

6. KARDEX and Nursing Care Plan I and II and Patient Assessment
7. Nursing notes
8. Instructor's guide
9. Student syllabus
10. References

Examination Modes

1. Response in classroom
2. Paper and pencil test
3. Rating on performance in simulated practice
4. Rating on performance in work situation (feedback)
5. Oral quiz on knowledge related to performance in simulated practice and work situation (feedback)

Training Time

0:45 hour didactic

0:45 hour supervised practice

LEARNING MODULE IE5
PATIENT CARE: WASHING AND SCRUBBING OF THE HANDS

Tasks

- _____ Wash hands prior to/after patient care, medications, treatments, examinations, procedures, specimen collecting/handling, etc.
- 145001 Perform hand scrubbing technique prior to surgical/sterile procedure

Performance Objective (Stimulus)

When a patient needs care and/or when assigned by a doctor, nurse, or senior corpsman/technician to give or assist in giving patient care, medications, treatments, and in performing examinations, tests, and procedures.

Performance Objective (Behavior)

The corpsman/technician will wash or scrub his hands, whichever is appropriate, prior to and after giving patient care, medications, and treatments; performing or assisting with examinations, tests, and procedures, within and without sterile fields.

Performance Objective (Conditions)

With supervision and without assistance.

Performance Objective (Criteria)

In accordance with established standard procedures for routine hand washing and scrubbing for surgery and isolation.

Performance Objective (Consequence)

Reduction in chances of contamination due to bacteria commonly found on the skin.

Performance Objective (Next Action)

Proceed with the work to be performed or put on surgical gloves.

Knowledge and Skills

1. Purpose and objectives of hand washing and scrubbing
2. Medical and surgical asepsis
3. Diseases and infections commonly transmitted by hands
4. Solutions and compounds used for hand washing and scrubbing
5. Procedures, techniques, and routines for hand washing and scrubbing

Instructional Strategies

1. Slides, filmstrips, films, videotapes and/or mediated programmed instruction (group or individual) on purpose, procedure, techniques, and routines for hand washing and hand scrubbing for surgery and isolation; consequence of improper washing and scrubbing.
2. Hardcover programmed instruction
3. Lecture
4. Discussion
5. Demonstration
6. Practice in simulated patient care unit
7. Study assignments
8. Written exercises

Training Aids

1. Filmstrips/films/videotapes
2. Mediated programmed instruction
3. Hardcover programmed instruction
4. Slides
5. Chalk board
6. Equipment and supplies
7. Instructor's guide
8. Student syllabus
9. References

Examination Modes

1. Response in classroom
2. Paper and pencil test
3. Rating on performance in simulated practice
4. Rating on performance in work situation (feedback)
5. Oral quiz on knowledge related to performance in simulated practice or work situation (feedback)

Training Time

0:30 hour didactic

0:30 hour supervised practice

LEARNING MODULE 1E6
PATIENT CARE: MOVING AND POSITIONING PATIENT

Tasks

- _____ Assist patient/move patient into prone/supine/side/Sims/Fowler position
- _____ Assist patient to sit on side of bed
- 110005 Assist patient in/out of bed, examination/O.R. table
- 110006 Assist patient to stand, walk, dangle
- 110101 Position patient for meals
- 110093 Position patient in alignment with adequate support

Performance Objective (Stimulus)

When a patient needs to be moved and positioned or when assigned to move and position a patient by the senior corpsman/technician, nurse, or doctor

Performance Objective (Behavior)

The corpsman/technician will move a patient who can help himself or a helpless patient; position him in supine, prone, Sims, Fowler, side, or upright positions and align the body.

Performance Objective (Conditions)

With selective supervision and with or without an assistant, depending on the patient's condition.

Performance Objective (Criteria)

In accordance with established standard procedures for moving and positioning patient properly and comfortably.

Performance Objective (Consequence)

Patient in appropriate position.

Performance Objective (Next Action)

To ascertain patient's required supplies, water, and food are within reach.

Knowledge and Skills

1. Purpose and objectives for moving and positioning patient
2. Anatomy and physiology of the musculoskeletal system
3. Body mechanics for lifting and moving patients
4. Operation of bed mechanics
5. Patient's disease, therapy, and condition as related to moving and positioning
6. Pressure points relative to different positions
7. Body positions and required support
8. Procedures and techniques for moving and positioning patient and aligning body

Instructional Strategies

1. Pretest and/or review on anatomy and physiology of musculoskeletal system; observation and communication skills; routines for reporting and recording.
2. Slides, filmstrip, film, videotape and/or mediated programmed instruction (individual or group) on purpose, procedures, techniques, and routines for moving and positioning patients in different positions and aligning body; body mechanics.
3. Hardcover programmed instruction
4. Lecture
5. Discussion
6. Demonstration
7. Practice in simulated patient care unit
8. Study assignments
9. Written exercises

Training Aids

1. Filmstrips/films/videotape
2. Mediated programmed instruction
3. Hardcover programmed instruction
4. Slides
5. Wall charts
6. Chalk board

7. Anatomical model
8. Equipment and supplies
9. Instructor's guide
10. Student syllabus
11. References

Examination Modes

1. Response in classroom
2. Paper and pencil test
3. Rating on performance in simulated practice
4. Rating on performance in work situation (feedback)
5. Oral quiz on knowledge related to performance in simulated practice and work situation (feedback)

Training Time

- 1:00 hour didactic
- 1:00 hour supervised practice

LEARNING MODULE IE7

PATIENT CARE: MOVING AND TRANSPORTING PATIENT

Tasks

- 150009 Determine method of moving and transporting patient
- 110005 Assist patient in/out of bed, examination/O.R. table
- 110107 Accompany/assist wheelchair patient to the rest room
- 110130 Take patient confined to bed/wheelchair outdoors
- 110032 Load/unload patients from stretchers
- 110057 Transport non-ambulatory patient to other departments/clinics
- 110132 Load/unload patients from ambulances
- 120107 Teach patient/family transfer techniques, i.e., bed to chair, chair to commode

Performance Objective (Stimulus)

When a patient needs to be moved and transported or when assigned by the senior corpsman/technician, nurse, or doctor to move and transport a patient.

Performance Objective (Behavior)

The corpsman/technician will assist the patient to move or move him from bed to bed, chair, wheelchair, commode or stretcher; from chair, wheelchair, commode or stretcher to bed; from wheelchair to toilet or examining table; from stretcher to examining table; and from examining table to wheelchair or stretcher. He will transport the patient to other hospital areas by bed, stretcher, or wheelchair. He will load onto and unload from ambulances ambulatory patients and assist with the loading and unloading of helpless patients and patients with limitations for self movement. He will teach patient and family moving, positioning, and transporting skills.

Performance Objective (Conditions)

With selective supervision and with or without an assistant, depending on the patient's condition.

Performance Objective (Criteria)

In accordance with established standard positions for moving and positioning properly and comfortably and transporting him safely.

Performance Objective (Consequence)

Patient in appropriate position and transported safely.

Performance Objective (Next Action)

To record care on nursing notes.

Knowledge and Skills

1. Purpose and objectives for moving and transporting patient
2. Anatomy and physiology of musculoskeletal system
3. Body mechanics for lifting and moving patients
4. Operation of various types of equipment used in moving and transporting patient
5. Patient's disease, therapy, and condition as related to moving and transporting
6. Pressure points relative to different positions
7. Safety precautions in transferring patient from one piece of equipment to another
8. Procedures and techniques for moving and transporting patient, aligning body, and giving support according to patient's limitations

Instructional Strategies

1. Pretest and/or review on anatomy and physiology of musculoskeletal system; body mechanics for lifting and moving patients; observation and communication skills; routines for reporting and recording.
2. Slides, filmstrips, films, videotape, and/or mediated programmed instruction (individual or group) on purpose, procedures, techniques, and routines for moving, positioning, and transporting patients.
3. Hardcover programmed instruction
4. Lecture
5. Demonstration
6. Discussion

7. Practice in simulated patient care unit
8. Study assignments
9. Written exercises

Training Aids

1. Filmstrips/films/videotapes
2. Mediated programmed instruction
3. Hardcover programmed instruction
4. Slides
5. Wall charts
6. Chalk board
7. Anatomical model
8. Equipment and supplies
9. Instructor's guide
10. Student syllabus
11. References

Examination Modes

1. Response in classroom
2. Paper and pencil test
3. Rating on performance in simulated practice
4. Rating on performance in work situation (feedback)
5. Oral quiz on knowledge related to performance in simulated practice and work situation (feedback)

Training Time

- 0:45 hour didactic
- 0:45 hour supervised practice

LEARNING MODULE IE8

PATIENT CARE: CLOTHING THE PATIENT AND MONITORING APPAREL

Tasks

- 110015 Assist patient in putting on clothes
- 110096 Change patient's soiled linen and clothes
- 110015 Clean and clothe the patient after surgery/treatment/examination
- 330340 Check personnel for required attire for entry and exit from department

Performance Objective (Stimulus)

When a patient needs assistance in clothing himself or is attired improperly, or when assigned by the senior corpsman/technician, nurse, or doctor to assist the patient in clothing himself and monitoring patient's attire.

Performance Objective (Behavior)

The corpsman/technician will select the proper clothing for the patient, assist him to clothe himself, and monitor his attire.

Performance Objective (Conditions)

With indirect supervision and without assistance, using the proper clothing and current official directives and notices.

Performance Objective (Criteria)

In accordance with established standard procedure and official instructions.

Performance Objective (Consequence)

Properly and correctly groomed patient.

Performance Objective (Next Action)

Continued monitoring of patient's apparel and grooming.

Knowledge and Skills

1. Purpose and objectives in clothing patient and monitoring apparel

2. Anatomy and physiology of musculoskeletal system
3. Patient's disease, therapy and condition as related to type and style of clothing and assistance required to clothe himself
4. Purpose and objectives of various types and styles of clothing
5. Policies, rules, and regulations governing required uniform and attire
6. Procedures and techniques for positioning and moving patient
7. Procedures and techniques for clothing patients with various types of limitations and in different positions

Instructional Strategies

1. Pretest and/or review on anatomy and physiology of musculoskeletal system; body mechanics; moving and positioning the patient; patient grooming; observation and communication skills; routines for reporting and recording.
2. Slides, filmstrips, films, videotapes and/or mediated programmed instruction (individual or group) on purpose, procedures, techniques, and routine, using various types of clothing for clothing patients with various types of limitations in different positions.
3. Hardcover programmed instruction
4. Lecture
5. Discussion
6. Demonstration
7. Practice in simulated patient care unit
8. Study assignments
9. Written exercises

Training Aids

1. Filmstrips/films/videotapes
2. Mediated programmed instruction
3. Hardcover programmed instruction
4. Slides
5. Chalk board
6. Official directives, instructions, and notices
7. Anatomical models
8. Equipment and supplies

9. Instructor's guide
10. Student syllabus
11. References

Examination Modes

1. Response in classroom
2. Rating on performance in simulated practice
3. Rating on performance in work situation (feedback)
4. Oral quiz on knowledge related to performance in simulated practice and work situation (feedback)

Training Time

0:30 hour didactic

LEARNING MODULE 1E9
PATIENT CARE: MAKING AN OCCUPIED BED

Tasks

- 110092 Make an occupied bed
- 110096 Change patient's soiled linen and clothing

Performance Objective (Stimulus)

When an occupied bed needs to be made and when assigned to make it by the senior corpsman/technician, nurse, or doctor.

Performance Objective (Behavior)

The corpsman/technician will turn, move, and position the patient, make the bed, and change the linen and the patient's clothing.

Performance Objective (Conditions)

With indirect supervision and with or without assistance, depending on patient's condition, using proper linens.

Performance Objective (Criteria)

In accordance with established standard procedures, techniques, and routines for making the bed and moving and positioning the patient.

Performance Objective (Consequence)

Newly made bed with clean linen and patient clothing.

Performance Objective (Next Action)

Clean and tidy the patient's unit.

Knowledge and Skills

1. Purpose and objectives for making an occupied bed
2. Patient's disease, therapy, and condition as related to moving and positioning patient for making an occupied bed

3. Procedures and techniques for making an occupied bed
4. Procedures and techniques for moving and positioning patient
5. Procedures and techniques for obtaining clean linen and clothing and disposing of soiled linen and clothing

Instructional Strategies

1. Pretest and/or review on anatomy and physiology of musculoskeletal system; body mechanics; procedures and techniques for moving and positioning a bed patient; observation and communication skills; routines for reporting and recording.
2. Slides, filmstrips, films, videotapes and/or mediated programmed instruction (individual or group) on purpose, procedures, techniques, and routines for making an occupied bed.
3. Hardcover programmed instruction
4. Lecture
5. Demonstration
6. Discussion
7. Practice in simulated patient care unit
8. Study assignments
9. Written exercises

Training Aids

1. Filmstrips/films/videotapes
2. Mediated programmed instruction
3. Hardcover programmed instruction
4. Chalk board
5. Anatomical models
6. Equipment and supplies
7. Instructor's guide
8. Student syllabus
9. References

Examination Modes

1. Response in classroom
2. Paper and pencil test
3. Rating on performance in simulated practice
4. Rating on performance in work situation (feedback)
5. Oral quiz on knowledge related to performance in simulated practice and work situation (feedback)

Training Time

0:30 hour didactic

0:45 hour supervised practice

LEARNING MODULE IE10
PATIENT CARE: ORAL HYGIENE AND MOUTH IRRIGATION

Tasks

- 110094 Give or help patient with oral hygiene, e.g., brush teeth, clean dentures, mouth wash
- 140360 Irrigate mouth or oral cavity
- 140234 Give antiseptic irrigation for gingivitis

Performance Objective (Stimulus)

When a patient needs oral hygiene and when assigned by a senior corpsman/technician, nurse, or doctor to give oral hygiene and mouth irrigations ordered by the doctor.

Performance Objective (Behavior)

The corpsman/technician will assist the patient with or give oral hygiene, including denture care and mouth washes, and administer mouth irrigations prescribed by the physician.

Performance Objective (Conditions)

With indirect supervision and without assistance, using appropriate equipment and supplies and correct solutions.

Performance Objective (Criteria)

In accordance with established standard procedures, techniques, and routines.

Performance Objective (Consequence)

Patient will receive appropriate oral hygiene and prescribed mouth irrigations.

Performance Objective (Next Action)

Clean and tidy the patient's unit.

Knowledge and Skills

1. Anatomy and physiology of the oral cavity, organs, and tissue
2. Patient's disease, therapy, and condition as related to oral hygiene care and mouth irrigations
3. Purpose and objectives of oral hygiene care and mouth irrigations
4. Procedures, techniques, and routines for giving oral hygiene, and mouth irrigations

Instructional Strategies

1. Pretest and/or review on anatomy and physiology of mouth and surrounding organs and tissues; observation and communication skills; routines for reporting and recording.
2. Slides, filmstrips, films, videotapes and/or mediated programmed instruction (individual or group) on purpose, procedures, techniques, and routines for giving oral hygiene and mouth irrigations.
3. Hardcover programmed instruction
4. Lecture
5. Demonstration
6. Discussion
7. Practice in simulated patient care unit
8. Study assignments
9. Written exercises

Training Aids

1. Filmstrips/films/videotapes
2. Mediated programmed instruction
3. Slides
4. Wall charts
5. Chalk board
6. Anatomical models
7. Equipment and supplies
8. Instructor's guide
9. Student syllabus
10. References

Examination Modes

1. Response in classroom
2. Paper and pencil test
3. Rating on performance in simulated practice
4. Rating on performance in work situation (feedback)
5. Oral quiz on knowledge related to performance in simulated practice and work situation (feedback)

Training Time

0:45 hour didactic

0:45 hour supervised practice

LEARNING MODULE IE11
PATIENT CARE: NAIL AND HAIR CARE

Tasks

- 110028 Groom patient, e.g., shampoo, comb hair, give toenail and fingernail care, shave beard
- 120102 Instruct patient in preventive care of fingernail and toenail abnormalities

Performance Objective (Stimulus)

When nail and/or hair care is needed or when assigned by senior corpsman/technician, nurse, or doctor to give nail and/or hair care.

Performance Objective (Behavior)

The corpsman/technician will shampoo and/or comb the hair; and/or shave the patient's beard; and/or give nail care with instructions for preventive nail care.

Performance Objective (Conditions)

With indirect supervision and without assistance, using appropriate equipment and supplies.

Performance Objective (Criteria)

In accordance with established standard procedures, techniques, and routines.

Performance Objective (Consequence)

Patient will have properly groomed and clean hair, appropriately shaved face, and trimmed nails.

Performance Objective (Next Action)

Clean and tidy the patient's unit.

Knowledge and Skills

1. Anatomy and physiology of skin, hair, and nails
2. Patient's disease, therapy, and condition as related to hair and nail care
3. Purpose and objectives of nail and hair care
4. Procedures and techniques for routine hair care, bed and sink shampoo, shaving beard, nail care

Instructional Strategies

1. Pretest and/or review on anatomy and functions of skin; observation and communication skills; routines for reporting and recording.
2. Slides, filmstrips, films, videotapes, and/or mediated programmed instruction (individual or group) on purpose, procedures, techniques, and routines for bed and sink shampoo, shaving beard, and nail care.
3. Hardcover programmed instruction
4. Lecture
5. Demonstration
6. Discussion
7. Practice in simulated patient care unit
8. Study assignments
9. Written exercises

Training Aids

1. Filmstrips/films/videotapes
2. Mediated programmed instruction
3. Hardcover programmed instruction
4. Slides
5. Wall charts
6. Chalk board
7. Anatomical models
8. Equipment and supplies
9. Instructor's guide
10. Student syllabus
11. References

Examination Modes

1. Response in classroom
2. Paper and pencil test
3. Rating on performance in simulated practice
4. Rating on performance in work situation (feedback)
5. Oral quiz on knowledge related to performance in simulated practice and work situation (feedback)

Training Time

0:30 hour didactic

0:45 hour supervised practice

LEARNING MODULE 1E12
PATIENT CARE: BATHING THE PATIENT

Tasks

- 110023 Give bed bath to patient
- 110027 Assist patient with tub, sitz bath, shower
- _____ Wash patient's face and hands

Performance Objective (Stimulus)

When a patient needs bathing or when assigned by the senior corpsman/technician, nurse, or doctor to bathe a patient, assist with his bathing, or wash his face and hands.

Performance Objective (Behavior)

The corpsman/technician will assist with or give a bed bath and the washing of the patient's face and hands and assist the patient with a tub bath or shower.

Performance Objective (Conditions)

With indirect supervision and without assistance, when indicated, using appropriate equipment and supplies.

Performance Objective (Criteria)

In accordance with established standard procedures, techniques, and routines.

Performance Objective (Consequence)

Patient's body will be clean.

Performance Objective (Next Action)

Clothe the patient or assist him to clothe and clean and tidy the unit.

Knowledge and Skills

1. Anatomy and physiology of musculoskeletal system and skin

2. Patient's disease, therapy, and condition relative to bathing and washing face and/or hands
3. Purpose and objectives for face and hand washing
4. Purpose and objectives of bed or tub bath and shower
5. Procedure and techniques for washing face and/or hands
6. Procedure and techniques for giving bed bath, tub bath, shower, and washing face and hands
7. Procedure and techniques for moving and positioning patient

Instructional Strategies

1. Pretest and/or review on anatomy and physiology of musculoskeletal system and skin, moving and positioning patient, observation and communication skills, routines for reporting and recording.
2. Slides, filmstrips, films, videotapes, and/or mediated programmed instruction (individual or group) on procedures, techniques, and routines for giving bed bath, assisting patient with tub and sitz bath and shower, and washing face and hands.
3. Hardcover programmed instruction
4. Lecture
5. Demonstration
6. Discussion
7. Practice in simulated patient care unit
8. Study assignments
9. Written exercises

Training Aids

1. Filmstrips/films/videotapes
2. Mediated programmed instruction
3. Hardcover programmed instruction
4. Chalk board
5. Anatomical models
6. Equipment and supplies
7. Instructor's guide
8. Student syllabus
9. References

Examination Modes

1. Response in classroom
2. Paper and pencil test
3. Rating on performance in simulated practice
4. Rating on performance in work situation (feedback)
5. Oral quiz on knowledge related to performance in simulated practice and work situation (feedback)

Training Time

0:45 hour didactic

1:00 hour supervised practice

AD-A085 706

TECHNOMICS INC OAKTON VA

A SYSTEM APPROACH TO NAVY MEDICAL EDUCATION AND TRAINING. APPEN--ETC (11)

F/O S/O

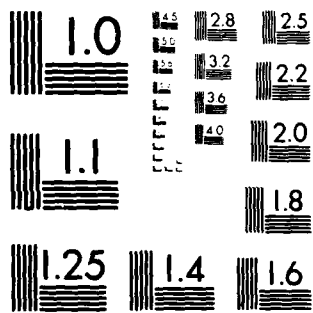
N00014-69-C-0246

AL

UNCLASSIFIED

21-7

ALL INFORMATION CONTAINED
HEREIN IS UNCLASSIFIED



MICROCOPY RESOLUTION TEST CHART
NATIONAL BUREAU OF STANDARDS-1010-A

LEARNING MODULE IE13
PATIENT CARE: DIETS AND NUTRITION

Tasks

- 110112 Help patient select food from menu
- 130308 Observe patient's eating patterns
- 120111 Teach family/patient health promotion practices, including exercise and diet
- 330143 Place special treatment tags over/on bed, e.g., fasting, force fluids

Performance Objective (Stimulus)

When needed by the patient or when assigned by the senior corpsman/technician, nurse, or doctor to assist a patient in diet selection and maintenance.

Performance Objective (Behavior)

The corpsman/technician will tag the patient's bed for special dietary action; observe his eating habits; help him select the proper diet items; and teach him about diets and their relation to his health.

Performance Objective (Conditions)

With indirect supervision and without assistance, using his knowledge about the patient and nutrition.

Performance Objective (Criteria)

In accordance with established standard procedures and practices.

Performance Objective (Consequence)

A patient who understands nutrition and diets as related to his condition.

Performance Objective (Next Action)

To serve diets.

Knowledge and Skills

1. Purposes and objectives of diet
2. Functions of food
3. Food composition
4. Caloric values
5. Balanced diets
6. Diets in disease
7. Classification of diets
8. Teaching techniques and content
9. Patient's disease, therapy, and condition as related to diet
10. Selection of food for patient's diet

Instructional Strategies

1. Pretest and/or review on physiology of food digestion and assimilation; communication and instructional skills; routine for reporting and recording.
2. Slides, filmstrips, films, videotapes, and/or mediated programmed instruction (individual and group) on nutrition and diet selection.
3. Hardcover programmed instruction
4. Lecture
5. Discussion
6. Practice in simulated patient care unit teaching patient food selection
7. Study assignments
8. Written exercises

Training Aids

1. Filmstrips/films/videotapes
2. Mediated programmed instruction
3. Hardcover programmed instruction
4. Slides
5. Chalk board
6. Felt board
7. Instructor's guide
8. Student syllabus
9. References

Examination Modes

1. Response in classroom
2. Paper and pencil test
3. Rating on performance in simulated practice
4. Rating on performance in work situation (feedback)
5. Oral quiz on knowledge related to performance in simulated practice and work situation (feedback)
6. Projects

Training Time

2:00 hours didactic

1:00 hour supervised practice

LEARNING MODULE IE14
PATIENT CARE: SERVING MEALS AND NOURISHMENT

Tasks

- 110101 Position the patient for meals
- 230248 Distribute/collect meal trays
- 110034 Pass nourishment to patient
- 340062 Check food in refrigerator/meal trays for freshness
- _____ Verify patient's diet and nourishment with diet and nourishment list

Performance Objective (Stimulus)

When needed by the patient or according to schedule and when assigned by the senior corpsman/technician, nurse, or doctor to serve meals and/or nourishment.

Performance Objective (Behavior)

The corpsman/technician will position the patient for eating; verify patient's diet and nourishment with diet and nourishment list; serve diets and nourishment and ascertain that food is fresh and unspoiled.

Performance Objective (Conditions)

With indirect supervision and with or without assistance, serving diets from food carts or central tray conveyor and serving nourishment and special diet items from refrigerator.

Performance Objective (Criteria)

In accordance with established standard procedures, techniques, and routines, using correct diet information.

Performance Objective (Consequence)

Patient will receive diet ordered by the physician.

Performance Objective (Next Action)

To assist patient in eating or feed him, or collecting food trays or nourishment equipment after use.

Knowledge and Skills

1. Purpose and objectives of diet service
2. Diet classification
3. Procedure for verification of diets
4. Procedure, techniques, and routines for positioning the patient for eating
5. Procedure and techniques for serving diets and nourishment

Instructional Strategies

1. Pretest and/or review on procedures for diet verification, positioning patient; observation and communication skills; routines for reporting and recording.
2. Slides, filmstrips, films, videotapes, and/or mediated programmed instruction (individual or group) on serving diets and nourishment.
3. Hardcover programmed instruction
4. Lecture
5. Discussion
6. Demonstration
7. Practice in simulated patient care unit
8. Practice in work situation
9. Study assignments

Training Aids

1. Filmstrips/films/videotapes
2. Mediated programmed instruction
3. Hardcover programmed instruction
4. Chalk board
5. Anatomical models
6. Equipment and supplies
7. Instructor's guide
8. Student syllabus
9. References

Examination Modes

1. Response in classroom
2. Paper and pencil test
3. Rating on performance in simulated practice
4. Rating on performance in work situation (feedback)
5. Oral quiz on knowledge related to performance in simulated practice and work situation (feedback)

Training Time

0:30 hour didactic

0:30 hour supervised practice

LEARNING MODULE IE15

PATIENT CARE: ASSISTING THE PATIENT TO EAT AND FEEDING THE PATIENT

Tasks

- 110101 Position the patient for meals
- 110004 Feed or help patient in eating

Performance Objective (Stimulus)

When needed by the patient or when assigned by the senior corpsman/technician, nurse, or doctor to assist patient in eating or to feed patient.

Performance Objective (Behavior)

The corpsman/technician will move the patient into the best position for eating; move his food to location where it can be reached easily; cut meat and prepare other food to facilitate patient's eating; and, if necessary, feed the patient.

Performance Objective (Conditions)

With indirect supervision and without assistance, using required equipment.

Performance Objective (Criteria)

In accordance with established standard procedures, techniques, and routines, using the correct diet.

Performance Objective (Consequence)

Patient will receive diet food ordered by the physician.

Performance Objective (Next Action)

Reposition patient and his bedside equipment.

Knowledge and Skills

1. Purpose and objectives of feeding patient or assisting him to eat
2. Physiology of ingesting food

3. Procedure and techniques for positioning the patient
4. Procedure and techniques for assisting the patient to eat
5. Procedures and techniques for feeding the patient

Instructional Strategies

1. Pretest and/or review on physiology of food ingestion; diets and nutrition; serving meals and nourishment; communication and observation skills; routines for reporting and recording.
2. Slides, filmstrips, films, videotapes, and/or mediated programmed instruction (individual or group) on purpose, procedures, techniques, and routines for positioning patient for eating, assisting him to eat, and feeding him.
3. Lecture
4. Demonstration
5. Discussion
6. Practice in simulated patient care unit
7. Study assignments
8. Written exercises

Training Aids

1. Filmstrips/films/videotapes
2. Mediated programmed instruction
3. Chalk board
4. Anatomical models
5. Equipment and supplies
6. Instructor's guide
7. Student syllabus
8. References

Examination Modes

1. Response in classroom
2. Paper and pencil test
3. Rating on performance in simulated practice
4. Rating on performance in work situation (feedback)

5. Oral quiz on knowledge related to performance in simulated practice and work situation (feedback)

Training Time

0:30 hour didactic

0:30 hour supervised practice

LEARNING MODULE IE16

PATIENT CARE: ASSISTING THE PATIENT WITH ELIMINATION

Tasks

- 110007 Assist patient with bedpans, urinals, commode chairs
_____ Give care to incontinent patient
110096 Change patient's soiled linen and clothing

Performance Objective (Stimulus)

When needed by the patient or when assigned by the senior corpsman/technician, nurse, or doctor to assist patient with bedpans, urinals, commode chairs, and to care for incontinency.

Performance Objective (Behavior)

The corpsman/technician will provide and assist in placing and removing the bedpan and/or urinal; assist patient onto and off from commode chairs, clean or assist in cleaning the helpless and incontinent patient; change clothing and linen if soiled and give care to incontinent patient.

Performance Objective (Conditions)

With indirect supervision and with or without assistance, depending on the patient's condition, using bedpans, urinals, and linen.

Performance Objective (Criteria)

In accordance with established standard procedures, techniques, and routines.

Performance Objective (Consequence)

Patient's elimination needs are met and he is left dry and clean.

Performance Objective (Next Action)

Follow up on incontinent patient's needs.

Knowledge and Skills

1. Purpose and objectives in assisting patient to use bedpan, urinal, commode, and changing an incontinent patient
2. Patient's disease, therapy, and condition as related to kidney and bowel function and elimination
3. Providing privacy for patient
4. Positioning of patient for use of bedpan and urinal
5. Moving and positioning patient on and off commode chair
6. Procedure and techniques for giving and removing bedpans and urinal and using commode chair
7. Procedure and techniques for giving care to incontinent patient, including special skin care

Instructional Strategies

1. Pretest and/or review on anatomy and physiology of executing system; procedures and techniques for moving and positioning patient; body mechanics; communication and observation skills; routines for reporting and recording.
2. Slides, filmstrips, films, videotapes, and/or mediated programmed instruction (individual and group) on purpose, procedures, techniques, and routines for giving and removing bedpans and urinal and for giving care to incontinent patient.
3. Hardcover programmed instruction
4. Lecture
5. Demonstration
6. Discussion
7. Practice in simulated patient care unit
8. Study assignments
9. Written exercises

Training Aids

1. Filmstrips/films/videotapes
2. Mediated programmed instruction
3. Hardcover programmed instruction
4. Chalk board
5. Anatomical models

6. Equipment and supplies
7. Instructor's guide
8. Student syllabus
9. References

Examination Modes

1. Response in classroom
2. Paper and pencil test
3. Rating on performance in simulated practice
4. Rating on performance in work situation (feedback)
5. Oral quiz on knowledge related to performance in simulated practice and work situation (feedback)

Training Time

- 1:00 hour didactic
- 0:30 hour supervised practice

LEARNING MODULE IE17
PATIENT CARE: REST AND SLEEP

Tasks

- 140084 Give massage for relaxation (sedative massage)
- 110054 Settle patient for rest period/night
- 110025 Ensure patients observe quiet hours

Performance Objective (Stimulus)

When a patient needs rest or sleep or when assigned by the senior corpsman/technician, nurse, or doctor to prepare a patient for rest and sleep and to enforce quiet hours.

Performance Objective (Behavior)

The corpsman/technician will position and make the patient comfortable and, if needed, give sedative message to the patient; discontinue patient unit activities except essential care; turn off all televisions, radios, etc.; dim or turn off lights and decrease temperature and increase ventilation of patient care unit.

Performance Objective (Conditions)

With indirect supervision and without assistance.

Performance Objective (Criteria)

In accordance with established standard procedures, techniques, and routines.

Performance Objective (Consequence)

Patient will be provided environment and care conducive to rest or sleep.

Performance Objective (Next Action)

Check on patient's comfort and patterns of rest and sleep.

Knowledge and Skill

1. Purpose and objectives for rest and sleep support
2. Regulations and routines for securing patient care unit for quiet hours and nights
3. Patient care prior to rest and sleep
4. Procedures and techniques for giving sedative massage

Instructional Strategies

1. Pretest and/or review on communication and observation skills; routines for reporting and recording
2. Slides, filmstrips, films, videotapes, and/or mediated programmed instruction (individual or group) on purposes, procedures, techniques, and routines for preparing the patient for sleep, including massage for relaxation and preparing environment.
3. Hardcover programmed instruction
4. Lecture
5. Demonstration
6. Discussion
7. Practice in simulated patient care unit
8. Study assignments
9. Written exercises

Training Aids

1. Filmstrips/films/videotapes
2. Mediated programmed instruction
3. Hardcover programmed instruction
4. Chalk board
5. Anatomical models
6. Equipment and supplies
7. Instructor's guide
8. Student syllabus
9. References

Examination Modes

1. Response in classroom
2. Paper and pencil test
3. Rating on performance in simulated practice
4. Rating on performance in work situation (feedback)
5. Oral quiz on knowledge related to performance in simulated practice and work situation (feedback)

Training Time

0:30 hour didactic

0:30 hour supervised practice

LEARNING MODULE IE18
PATIENT CARE: ACTIVITY AND EXERCISE

Tasks

- 130434 Assess patient's tolerance for exercise and activity
130384 Observe for/report patient's level of physical activity, e.g., lethargy, hyperactivity

Performance Objective (Stimulus)

When caring for a patient and/or when assigned by the senior corpsman/technician, nurse, or doctor to observe and evaluate the extent of a patient's physical activity and tolerance for activity and exercise.

Performance Objective (Behavior)

The corpsman/technician will observe the patient's level of physical activity, such as inertia, lethargy, hesitance or reluctance to move, restlessness, and extensive hyperactivity; and assess his tolerance for exercise and activity, such as sitting up in bed, getting out of bed, walking, giving his own care, and performing assigned tasks.

Performance Objective (Conditions)

With indirect supervision and without assistance.

Performance Objective (Criteria)

Relative to the patient's disease, therapy, and state of recovery.

Performance Objective (Consequence)

Assessment of patient's capability for physical activity and exercise, e.g., fatigue, difficult breathing, irritability.

Performance Objective (Next Action)

Determine possible causes of patient's status of physical activity and extent of tolerance for exercise if limited.

Knowledge and Skills

1. Purpose and objectives for observing and assessing patient's activity and tolerance for activity and exercise
2. Techniques for observing physical activity and effect of exercise
3. Patient's disease, therapy, and treatment as related to physical activity
4. Criteria for assessing status of physical activity and extent of exercise

Instructional Strategies

1. Slides, filmstrips, films, videotapes, and/or mediated programmed instruction (individual or group) on levels of physical activity and symptoms of intolerance to exercise.
2. Hardcover programmed instruction
3. Lecture
4. Discussion
5. Study assignments
6. Written exercises

Training Aids

1. Filmstrips/films/videotapes
2. Mediated programmed instruction
3. Hardcover programmed instruction
4. Chalk board
5. Instructor's guide
6. Student syllabus
7. References

Examination Modes

1. Response in classroom
2. Paper and pencil test
3. Rating on performance in work situation (feedback)
4. Oral quiz on knowledge related to performance in work situation (feedback)

Training Time

0:30 hour didactic

LEARNING MODULE IE19
PATIENT CARE: OBSERVATIONS OF PATIENT BEHAVIOR

Tasks

- 130051 Observe patient's behavior pattern
- 130381 Observe patient's appearance, e.g., dress, grooming
- 130389 Observe for/report patient's level of physical activity, e.g., lethargy, hyperactivity
- 130098 Observe patient's pattern of interaction with others
- 130578 Observe effect of visitors on patient
- 130264 Observe for/report or describe symptoms of irritability, restlessness, apprehension
- 130382 Observe/record patient's physical/emotional response to treatment/diagnostic procedure
- 130574 Observe for patient's need to ventilate feelings
- 130354 Observe for patient's general mental behavior

Performance Objective (Stimulus)

When caring for a patient and/or when assigned by the senior corpsman/technician, nurse, or doctor to observe a patient's behavior.

Performance Objective (Behavior)

The corpsman/technician will observe the patient's dress and grooming; level of physical activity; interaction with others; reaction to visitors; irritability, restlessness, and apprehension; response to care, treatments, and examinations; and ventilation of feelings, such as crying and temper tantrums and compare these observations to criteria accepted as normal behavior.

Performance Objective (Conditions)

With indirect supervision and without assistance.

Performance Objective (Criteria)

In accordance with accepted behavior standards.

Performance Objective (Consequence)

Information for evaluating patient's behavior.

Performance Objective (Next Action)

Determine possible causes for aberrant behavior.

Knowledge and Skills

1. Purpose and objectives in observing patient's behavior
2. Anatomy and physiology of the nervous system
3. Patient's disease, therapy, and treatment as related to behavior
4. Patient's prognosis as related to behavior
5. Patient's philosophy of life--religious, personal, family, or social as related to illness
6. Techniques for observing behavior
7. Criteria for determining normal and abnormal behavior and extent of abnormality
8. Describing behavior

Instructional Strategies

1. Pretest and/or review on anatomy and physiology of the nervous system
2. Slides, filmstrips, films, videotapes, and/or mediated programmed instruction (individual or group) on normal and unusual or abnormal dress and grooming, level of physical activity, interaction with others, and emotional reactions.
3. Hardcover programmed instruction
4. Lecture
5. Discussion
6. Role playing
7. Study assignments
8. Written exercises

Training Aids

1. Filmstrips/films/videotapes
2. Mediated programmed instruction

3. Hardcover programmed instruction
4. Slides
5. Chalk board
6. Instructor's guide
7. Student syllabus
8. References

Examination Modes

1. Response in classroom
2. Paper and pencil test
3. Response to mediated behavioral problems
4. Rating on performance in work situation (feedback)
5. Oral quiz on knowledge related to performance in work situation (feedback)

Training Time

2:00 hours didactic

0:30 hour response to mediated behavioral problems

LEARNING MODULE IE20
PATIENT CARE: SAFETY AND RESTRAINT

Tasks

- 110053 Restrain/control patient verbally
- 110091 Adjust siderails/height of bed for patient comfort/safety
- 110145 Restrain/control patient with an armhold
- 110052 Restrain patients; e.g., linen, leather straps, Posie belt, blanket wraps

Performance Objective (Stimulus)

When a patient needs restraining or when assigned by the senior corpsman/ technician, nurse, or doctor to apply physical restraints as ordered by the doctor.

Performance Objective (Behavior)

The corpsman/technician will provide safety to the patient by adjusting the height of the bed and adjusting siderails; will control the patient by verbal communication and/or an armhold; and the application of physical restraints ordered by the physician such as linen or blanket wraps, leather straps and Posie belt.

Performance Objective (Conditions)

With selective supervision and with or without assistance, depending on condition of patient.

Performance Objective (Criteria)

In accordance with established standard procedures, techniques, and routines.

Performance Objective (Consequence)

Safety for the patient and for others.

Performance Objective (Next Action)

Check on applied restraints and level of patient's activity.

Knowledge and Skills

1. Purpose and objectives for restraining patient and ensuring safety
2. Patient's disease, therapy, and treatment as related to hyperactivity and need for safety precautions
3. Observation skills in assessing patient's behavior and/or hyperactivity
4. Communication skills for allaying anxiety and hyperactivity
5. Procedures, techniques, and routines for applying armhold, adjusting bed and siderails, applying linen and blanket wraps, ankle and wrist straps, and Posie belt.

Instructional Strategies

1. Pretest and/or review on observation and communication skills, routines for reporting and recording
2. Slides, filmstrips, films, videotapes, and/or mediated programmed instruction (individual or group) on purpose, procedures, techniques, and routines for applying restraint to patient activity
3. Hardcover programmed instruction
4. Lecture
5. Demonstration
6. Discussion
7. Practice in simulated patient care unit
8. Role playing
9. Study assignments
10. Written exercises

Training Aids

1. Filmstrips/films/videotapes
2. Mediated programmed instruction
3. Hardcover programmed instruction
4. Chalk board
5. Anatomical models
6. Equipment and supplies
7. Instructor's guide
8. Student syllabus
9. References

Examination Modes

1. Response in classroom
2. Paper and pencil test
3. Rating on performance in simulated practice
4. Rating on performance in work situation (feedback)
5. Oral quiz on knowledge related to performance in simulated practice and work situation (feedback)

Training Time

- 1:00 hour didactic
- 1:00 hour supervised practice

LEARNING MODULE IE21
PATIENT CARE: RECREATION

Tasks

- 120268 Suggest books (fiction/non-fiction) to patient for therapeutic purposes
- 110088 Read to patient
- 110143 Conduct game activities for hospitalized patients
- 120269 Encourage patient to participate in social activities, e.g., parties, sports
- 120120 Inform patient/family of recreational activities in civilian community, e.g., senior citizens clubs

Performance Objective (Stimulus)

When needed by the patient and/or when assigned by the senior corpsman/technician, nurse, or doctor to provide recreational activities for the patient.

Performance Objective (Behavior)

The corpsman/technician will assess the patient's capability for passive or active exercise; determine the patient's interest in different diversional activities; and provide or make those activities available to him.

Performance Objective (Conditions)

With indirect supervision and without assistance.

Performance Objective (Criteria)

In accordance with common practice and according to the rules and regulations governing patient's recreational activities.

Performance Objective (Consequence)

Recreation for the patient.

Performance Objective (Next Action)

Follow up on patient's participation.

Knowledge and Skills

1. Purpose and objectives of recreational activities
2. Patient's disease, therapy, and treatment as related to the level and kind of recreational activity
3. Libraries, sports, theaters, social facilities available to the patient
4. Communication skills to elicit information from and give information to the patient relative to his physical capability and interest

Instructional Strategies

1. Pretest or review on communication skills
2. Mediated programmed instruction on purpose of recreation and recreational resources for the patient
3. Hardcover programmed instruction
4. Lecture
5. Discussion
6. Study assignments
7. Written exercises

Training Aids

1. Mediated programmed instruction
2. Hardcover programmed instruction
3. Chalk board
4. Instructor's guide
5. Student syllabus
6. References

Examination Modes

1. Response in classroom
2. Paper and pencil test
3. Rating on performance in work situation (feedback)
4. Oral quiz on knowledge related to performance in work situation (feedback)

Training Time

0:30 hour didactic

LEARNING MODULE IE22

PATIENT CARE: PATIENTS WITH COMMUNICATION PROBLEMS

Tasks

- 130380 Observe patient's ability to receive or express spoken, written, or printed communication
- 140341 Give care to patients who cannot speak or understand English
- 140341 Give care or assist patients with hearing/speech/sight loss
- 150108 Develop communication techniques for patient with communication problem, e.g., cards

Performance Objective (Stimulus)

When giving care to a patient and/or when assigned by the senior corpsman/technician, nurse, or doctor to give care to a patient with loss of hearing, sight, and/or speech or who does not understand English.

Performance Objective (Behavior)

The corpsman/technician will evaluate the patient's problem; develop ways of solving the problem; and test them.

Performance Objective (Conditions)

With selective supervision and without assistance.

Performance Objective (Criteria)

In accordance with common practices.

Performance Objective (Consequence)

Development of basic communication capability between patient and staff.

Performance Objective (Next Action)

Broaden or extend basic communication capability between patient and staff.

Knowledge and Skills

1. Purpose and objectives for developing communication methods
2. Patient's disease, therapy, and treatment as related to communication problem
3. Procedures and techniques for communicating with and caring for patients with loss of sight, hearing, and speech
4. Instructional techniques for teaching essential English words to non-English speaking patient
5. Observation techniques for assessing patient's ability to communicate verbally and/or in writing

Instructional Strategies

1. Pretest and/or review on communication and observation skills; routines for reporting and recording
2. Slides, filmstrips, films, videotapes, and/or mediated programmed instruction (individual or group) on capabilities and limitations of patients with loss of speech, hearing, and/or sight; techniques for teaching essential English to non-English speaking patient.
3. Hardcover programmed instruction
4. Lecture
5. Discussion
6. Demonstration
7. Role playing
8. Study assignments
9. Written exercises

Training Aids

1. Filmstrips/films/videotapes
2. Mediated programmed instruction
3. Hardcover programmed instruction
4. Chalk board
5. Equipment and supplies
6. Instructor's guide
7. Student syllabus
8. References

Examination Modes

1. Response in classroom
2. Paper and pencil test
3. Rating on performance in simulated practice
4. Rating on performance in work situation (feedback)
5. Oral quiz on knowledge related to performance in simulated practice and work situation (feedback)

Training Time

1:00 hour didactic

1:00 hour simulated practice

LEARNING MODULE IE23
PATIENT CARE: MEASURE AND WEIGH PATIENTS

Tasks

130084 Measure/weigh patient or personnel

Performance Objective (Stimulus)

When a patient is admitted and/or when assigned by the senior corpsman/technician, nurse, or doctor to measure or weight a patient.

Performance Objective (Behavior)

The corpsman/technician will weigh the patient and measure his height.

Performance Objective (Conditions)

With indirect supervision and with or without an assistant, depending upon the condition of the patient.

Performance Objective (Criteria)

In accordance with established standard procedures, techniques, and routines, using appropriate and balanced scales.

Performance Objective (Consequence)

Current accurate weight and height of patient.

Performance Objective (Next Action)

Continue with admission routine and/or make patient comfortable.

Knowledge and Skills

1. Purpose and objective for measuring and weighing patient
2. Normal weight range for height, age, and sex
3. Observation of patient's body build, obesity, under weight, edema
4. Procedure and technique for weighing and measuring patient's height

5. Patient's weight history, especially recent changes
6. Patient's disease, therapy, and treatment relative to weight

Instructional Strategies

1. Pretest and/or review on communication and observation skills, routines for reporting and recording
2. Slides, filmstrips, films, videotapes, and/or mediated programmed instruction (individual or group) on body builds, diseases, and therapy as related to weight; procedures, techniques, and routines for weighing and measuring.
3. Hardcover programmed instruction
4. Lecture
5. Demonstration
6. Discussion
7. Practice in simulated patient care unit
8. Study assignments
9. Written exercises

Training Aids

1. Filmstrips/films/videotapes
2. Mediated programmed instruction
3. Hardcover programmed instruction
4. Slides
5. Wall charts
6. Chalk board
7. Equipment and supplies
8. Instructor's guide
9. Student syllabus
10. References

Examination Modes

1. Response in classroom
2. Paper and pencil test
3. Rating on performance in simulated practice

4. Rating on performance in work situation (feedback)
5. Oral quiz on knowledge related to performance in simulated practice and work situation (feedback)

Training Time

0:30 hour didactic

0:15 hour supervised practice

LEARNING MODULE IE24
PATIENT CARE: SECURITY OF PATIENT'S PROPERTY

Tasks

- 110050 Remove, secure, and return patient's personal effects
130012 Check patient for prostheses, e.g., eyes, teeth, extremities

Performance Objective (Stimulus)

When assigned by the senior corpsman/technician, nurse, or doctor to admit a patient, care for a mentally confused or incompetent patient, place a patient on the seriously or critically ill list, and/or a patient is to receive a general anesthesia.

Performance Objective (Behavior)

The corpsman/technician will explain to the patient about the security of his valuables, remove and secure them, and check the patient for prostheses and, if indicated, remove and secure them.

Performance Objective (Conditions)

With indirect supervision and without assistance.

Performance Objective (Criteria)

In accordance with established policy, rules, and regulations.

Performance Objective (Consequence)

Safety of patient's valuables and prostheses.

Performance Objective (Next Action)

Return valuables and/or prostheses to patient when appropriate.

Knowledge and Skills

1. Purpose and objectives for providing security for patient's property
2. Policies, rules, and regulations governing safety of patient's property

3. Procedure and techniques for determining presence of valuables and prosthesis of unconscious patient
4. Communication techniques for explaining policies, rules, and regulations to patient
5. Procedure and techniques for safeguarding patient's property

Instructional Strategies

1. Pretest and/or review on communication and observation skills, routines for reporting and recording
2. Slides, filmstrips, films, videotapes, and/or mediated programmed instruction (individual or group) on purpose, procedures, techniques, and routines for safeguarding patient's valuables.
3. Hardcover programmed instruction
4. Lecture
5. Discussion
6. Study assignments
7. Written exercises

Training Aids

1. Filmstrips/films/videotapes
2. Mediated programmed instruction
3. Hardcover programmed instruction
4. Chalk board
5. Instructor's guide
6. Student syllabus
7. References

Examination Modes

1. Response in classroom
2. Paper and pencil test
3. Rating on performance in work situation (feedback)
4. Oral quiz on knowledge related to performance in work situation (feedback)

Training Time

0:30 hour didactic

LEARNING MODULE IE25

PATIENT CARE: VERY SERIOUSLY ILL AND DYING PATIENTS

Tasks

- 110098 Administer the sacraments, e.g., last rites, baptism
- 110099 Assist patient in religious rites, e.g., praying, reading scriptures
- 120123 Listen to patient/family express feelings of death
- 120125 Listen to patient/family express feelings of grief, guilt
- 150011 Confer with the chaplain to discuss patient/family needs/problems
- 120124 Comfort the dying patient

Performance Objective (Stimulus)

When assigned by the doctor, nurse, or senior corpsman/technician to give care to the very seriously ill and dying patient.

Performance Objective (Behavior)

The corpsman/technician will remain near the patient; listen to him express his feelings about death, his guilt and concern for others; provide him with religious support; and comfort him. He will listen to the family express their feelings and give them support. He will seek the chaplain's assistance in meeting the patient's and family's needs and problems.

Performance Objective (Conditions)

With selective supervision and with or without an assistant, depending upon the patient's condition.

Performance Objective (Criteria)

Using good observation skills and appropriate communication skills.

Performance Objective (Consequence)

The patient will have human contact during the final hours of his life.

Performance Objective (Next Action)

Comfort the patient's family when death occurs.

Knowledge and Skills

1. Purpose of his presence with the patient and family
2. Use of communication techniques--when to listen and when and how to verbalize
3. Observation techniques for observing patient's condition, behavior, and needs and those of his family
4. General patient care for the very critically ill and dying patient

Instructional Strategies

1. Pretest and/or review on communication and observation skills, routines for reporting and recording
2. Slides, filmstrips, films, videotapes, and/or mediated programmed instruction (individual or group) on the very seriously ill patient in terminus
3. Hardcover programmed instruction
4. Lecture
5. Discussion
6. Demonstration
7. Role playing
8. Study assignments
9. Written exercises

Training Aids

1. Filmstrips/films/videotapes
2. Mediated programmed instruction
3. Hardcover programmed instruction
4. Slides
5. Chalk board
6. Instructor's guide
7. Student syllabus
8. References

Examination Modes

1. Response in classroom
2. Paper and pencil test

3. Rating on performance in work situation (feedback)
4. Oral quiz on knowledge related to performance in simulated practice and work situation (feedback)

Training Time

0:30 hour didactic

0:30 hour supervised practice

LEARNING MODULE 1E26

POST MORTEM CARE

Tasks

- 110026 Give post mortem care
- 110062 Transport the body, complete with documents, to the morgue
- 330139 Prepare personal effects reports as required

Performance Objective (Stimulus)

When assigned by the doctor, nurse, or senior corpsman/technician to give post mortem care.

Performance Objective (Behavior)

The corpsman/technician will screen the patient's unit; replace dentures; change dressings; remove drainage tubes; close draining wounds with adhesive tape; bathe the body; pad the rectum and pubic regions; align the body and place arms on chest; wrap and tag the body and place on stretcher; notify morgue watch; transfer body to morgue; inventory personal effects; record death on nursing notes and close records.

Performance Objective (Conditions)

With selective supervision and with an assistant.

Performance Objective (Criteria)

According to policies and established standard routines, procedures, and techniques.

Performance Objective (Consequence)

Post mortem care will be given, the body removed from the ward unit, and the patient's records closed.

Performance Objective (Next Action)

Replenish morgue box and clean patient's unit.

Knowledge and Skills

1. Purpose of post mortem care
2. Procedures, techniques, and routines for giving post mortem care, removal of body from ward unit, inventorying personal effects, and closing patient's records.

Instructional Strategies

1. Slides, filmstrips, films, videotapes, and/or mediated programmed instruction (individual or group) on procedures, techniques, and routines for giving post mortem care, removing body from ward unit, inventorying personal effects, and closing patient's record.
2. Hardcover programmed instruction
3. Lecture
4. Discussion
5. Demonstration
6. Practice in simulated patient care unit
7. Study assignments
8. Written exercises

Training Aids

1. Filmstrips/films/videotapes
2. Mediated programmed instruction
3. Hardcover programmed instruction
4. Chalk board
5. Anatomical models
6. Equipment and supplies
7. Instructor's guide
8. Student syllabus
9. References

Examination Modes

1. Response in classroom
2. Paper and pencil test
3. Rating on performance in simulated practice

4. Rating on performance in work situation (feedback)
5. Oral quiz on knowledge related to performance in simulated practice and work situation (feedback)

Training Time

0:45 hour didactic

0:45 hour supervised practice

TRAINING UNIT IF
COLLECTING AND HANDLING SPECIMENS AND LABORATORY REPORTS

Learning Modules

- IF1. Specimens: Collecting and Handling of Voided Urine
- IF2. Specimens: Collecting and Handling of Feces
- IF3. Specimens: Collecting and Handling of Upper Respiratory Tract and Ear Secretions
- IF4. Specimens: Collecting and Handling of Drainage from Body Orifices and Open Wounds
- IF5. Specimens: Collecting and Handling of Blood
- IF6. Specimens: Collecting and Handling of Specimens not Ordered
- IF7. Specimens: Follow-up on Laboratory Reports

Training Objective

Upon completion of this training unit, the learner must be able to collect, prepare, label, and send to the laboratory for routine or emergency examination routine and clean-catch voided urine specimens; feces specimens obtained from stools, by glove technique and low enema; expectorated sputum specimens; nose and throat specimens obtained by sterile swab or suction for routine examination and for culture; specimens of drainage from eyes, ears, throat, urethra, vagina as smears or for culture; and capillary blood specimens obtained by pricking and venous blood specimens obtained by syringe and needle or by vacutainer for blood count, chemistry, sedimentation rate, clotting time, glucose tolerance, culture, Bromsulphalein test, and typing and cross-matching. He must be able to verify the test ordered by the doctor for which the specimen is to be collected and the patient's identity from whom it is to be collected. He must be able to communicate with the patient about the specimen collection and, if necessary, instruct the patient on how to collect it. He must be able to observe for abnormal or unusual characteristics of urine, feces, sputum, secretions from upper respiratory tract and ears, vomitus, and drainage from body orifices and open wounds and procure specimens for evaluation by the nurse or doctor and/or sending to the laboratory. He must be able to evaluate the patient's complaints and reaction to

procedures used in collecting specimens. He must be able to record on the necessary records specimen collection procedures and patient response, and specimens sent to the laboratory. He must be able to follow up on laboratory reports and recognize abnormal findings.

The learner must be able to perform the above with or without assistance, depending upon the patient's condition, and usually with indirect or selective supervision; however, in some instances he may need supervision. He must be able to perform according to established standard procedures, techniques, routines, and acceptable practices, making use of available equipment and supplies. The results of his performance are specimens properly collected, prepared, and sent to the laboratory; the collecting of abnormal specimens for evaluation and/or sending to the laboratory and the follow up on return of laboratory reports and reported abnormal findings.

Knowledge and Skills

1. Anatomy and physiology of bladder and urethra, vaginal tract, lower gastro-intestinal tract and rectum, naso-pharynx and upper respiratory tract, external eyes and ears, and blood vessels and surrounding body tissue.
2. Normal and abnormal characteristics of urine, feces, sputum, secretions from upper respiratory tract and ears, vomitus, and drainage from body orifices and open wounds.
3. Observation skills as related to identifying abnormalities in urine, feces, sputum, secretions, and drainage and for evaluating patient's response to procedures used in collecting specimens.
4. Communication skills for explaining specimen collections and tests to patient and reporting abnormalities to nurse or doctor.
5. Instructional skills for teaching patient to collect specimens
6. Verification of doctor's orders for tests
7. Verification of patient's identity
8. Purpose of tests: routine and emergency urine, stool, sputum, secretions, drainage, and blood.
9. Patient's diagnosis, therapy, and treatment relative to ordered test
10. Contraindications for procedures or tests
11. Procedures and techniques for obtaining and sending specimens to the laboratory.

12. Sterile techniques for obtaining cultures and blood
13. Procedures and techniques for handling specimens for routine and emergency tests
14. Recording of specimen collection and sending to laboratory
15. Follow-up on laboratory reports and identification of abnormal findings

Instructional Strategies

1. Pretest and/or review on anatomy and physiology of gastrointestinal, respiratory and urinary tracts, body orifices and blood vessels; communication and observation skills; routine for verifying doctor's orders and patients' identity; routines for reporting and recording.
2. Slides, filmstrips, films, videotapes, and/or mediated programmed instruction (individual or group) on purpose, procedures, techniques, and routines for collecting and handling urine, stools, respiratory tract, drainage from wounds and body orifices, and blood specimens, and following up on return of laboratory reports and findings.
3. Hardcover programmed instruction
4. Lecture
5. Discussion
6. Demonstration
7. Practice in simulated patient care unit
8. Study assignments
9. Written exercises

Training Aids

1. Filmstrips/films/videotapes
2. Mediated programmed instruction
3. Hardcover programmed instruction
4. Slides
5. Wall charts
6. Chalk board
7. Anatomical models
8. Equipment and supplies
9. Instructor's guide
10. Student syllabus
11. References

Examination Modes

1. Response in classroom
2. Paper and pencil test
3. Rating on performance in simulated practice
4. Rating on performance in work situation (feedback)
5. Oral quiz on knowledge related to performance in simulated practice and work situation (feedback)

Training Time

4:15 hours didactic

3:15 hours supervised practice

LEARNING MODULE IF1
SPECIMENS: COLLECTING AND HANDLING OF VOIDED URINE

Tasks

- 150137 Ensure that doctor's orders are carried out
- 110063 Verify identification of the patient, e.g., treatment/medication/
examination
- 120010 Explain/answer patient's questions regarding examination/test/
treatment/procedure
- 120131 Ask patient to collect specimen
- 120132 Check with patient to ensure that he has collected specimen as
instructed
- 259001 Prepare, label, and send routine specimens, e.g., urine, blood, to
laboratory
- 259015 Assist patient in collecting clean-catch urine
- _____ Prepare, label, and send emergency specimens to the laboratory
- 150064 Write nursing notes
- _____ Record on TPR graphic chart
- _____ Check off on nursing care plan

Performance Objective (Stimulus)

When assigned by the senior corpsman/technician, nurse, or doctor to collect routine or clean-catch urine specimen ordered by the doctor and send to the laboratory.

Performance Objective (Behavior)

The corpsman/technician will verify the specimen to be collected and the patient from whom it is to be collected; explain to the patient the requirement for a urine specimen and ensure that he understands the instructions on collecting it; prepare and label the collected specimen and attach the laboratory request for examination ordered by the doctor; send specimen to the laboratory for routine or emergency examinations and record specimen on nursing notes, TPR graphic chart and nursing care plan.

Performance Objective (Conditions)

With indirect supervision and without assistance.

Performance Objective (Criteria)

In accordance with established procedures, techniques, and routines, using the correct containers and laboratory request.

Performance Objective (Consequence)

Urine specimen sent to laboratory for ordered examination.

Performance Objective (Next Action)

Follow-up on return of laboratory report.

Knowledge and Skills

1. Procedure for verification of ordered specimen to be collected
2. Procedure for verification of patient's identity
3. Purpose of routine and clean-catch urine specimens
4. Patient's disease, therapy, and condition relative to the specimen test
5. Communication techniques for explaining to the patient procedure to be carried out in collecting specimen
6. Instructional techniques for teaching the patient how to collect the specimen
7. Procedure and techniques for collecting, preparing, and labeling specimen and sending it to the laboratory
8. Preparations and use of laboratory request to accompany specimen to laboratory
9. Procedure and techniques for collecting and handling routine and emergency specimens
10. Recording specimen collection and sending to laboratory on nursing notes, TPR graphic chart, and nursing care plan
11. Cleaning and disposal of used equipment and supplies

Instructional Strategies

1. Pretest and/or review on anatomy and physiology of urinary tract; communication and instructional skills; routines for verifying doctor's order and patient's identity; and routines for reporting and recording.

2. Slides, filmstrips, films, videotapes, and/or mediated programmed instruction (individual or group) on procedure, techniques, and routines for collecting, preparing, and sending routine and clean-catch voided urine specimens to laboratory.
3. Hardcover programmed instruction
4. Lecture
5. Discussion
6. Demonstration
7. Practice in simulated patient care unit
8. Study assignments
9. Written exercises

Training Aids

1. Filmstrips/films/videotapes
2. Mediated programmed instruction
3. Hardcover programmed instruction
4. Slides
5. Chalk board
6. Equipment and supplies
7. Instructor's guide
8. Student syllabus
9. References

Examination Modes

1. Response in classroom
2. Paper and pencil test
3. Rating on performance in simulated practice
4. Rating on performance in work situation (feedback)
5. Oral quiz on knowledge related to performance in simulated practice and work situation (feedback)

Training Time

0:30 hour didactic

0:30 hour supervised practice

LEARNING MODULE IF2
SPECIMENS: COLLECTING AND HANDLING OF FECES

Tasks

- 150137 Ensure that doctor's orders are carried out
- 110063 Verify identification of the patient, e.g., treatment/medication/
examination
- 120010 Explain/answer patient's questions regarding examination/test/
treatment/procedure
- 120131 Ask patient to collect specimen
- 120132 Check with patient to ensure that he has collected specimen as
instructed
- 150078 Ask patient/check chart for contraindication of treatment, pro-
cedure, or tests
- _____ Collect stool specimen using glove technique
- _____ Collect stool specimen using low enema
- _____ Collect, prepare, label, and send stool specimen to laboratory for
occult blood
- 259035 Collect rectal specimens using sterile swab
- 259021 Prepare, label, and send stool sample to laboratory for ova and
parasite testing
- _____ Collect, prepare, label, and send stool specimen to laboratory for amoeba
- _____ Collect, prepare, label, and send stool specimen to laboratory for
guaiac acid
- _____ Prepare, label, and send emergency specimens to the laboratory
- 130436 Evaluate patient's complaints or symptoms of pain
- 130382 Observe and record patient's physical/emotional response to
treatment/diagnostic procedure
- 150064 Write nursing notes
- _____ Record on TPR graphic chart
- _____ Check off on patient care plan

Performance Objective (Stimulus)

When assigned by the senior corpsman/technician, nurse, or doctor to collect
a specimen of feces ordered by the doctor and send to the laboratory.

Performance Objective (Behavior)

The corpsman/technician will verify the specimen to be collected and the patient from whom it is to be collected; explain to the patient the requirement for the specimen and how it is to be collected; recognize any contraindication for the collection procedure; collect a specimen from an evacuated stool or by glove, sterile swab, or enema procedure; evaluate the patient's reaction to the collection procedure; prepare, label, and send specimen to laboratory for routine and emergency examination; and record on nursing notes, TPR graphic sheet, and nursing care plan.

Performance Objective (Conditions)

With indirect supervision and without assistance.

Performance Objective (Criteria)

In accordance with established standard procedures, techniques, and routines, using proper equipment and correct laboratory request.

Performance Objective (Consequence)

Specimen of feces sent to laboratory for ordered examination.

Performance Objective (Next Action)

Follow-up on return of laboratory report.

Knowledge and Skills

1. Anatomy and physiology of lower gastro-intestinal tract and rectum
2. Procedure for verification of ordered specimen to be collected
3. Procedure for verification of patient's identity
4. Purpose for which specimen is collected
5. Patient's disease, therapy, and condition as related to evaluation of stool specimen and tests
6. Communication techniques for explaining to the patient procedure to be carried out in collecting specimen
7. Instructional techniques for teaching the patient to collect specimen from routine bowel evacuation

8. Procedure and techniques for collecting specimen from stool and, by using glove, sterile swab, and low enema procedures
9. Procedure and techniques for preparing, labeling, and sending stool specimen to laboratory for examination for occult blood, ova and parasites, amoeba, guaiac acid.
10. Observation techniques for assessing patient's reaction to procedure and complaints
11. Preparation of laboratory request
12. Recording specimen collection and sending to laboratory on nursing notes, TPR graphic sheet, and patient care plan
13. Cleaning and disposal of used equipment and supplies

Instructional Strategies

1. Pretest and/or review on anatomy and physiology of lower gastro-intestinal tract and rectum; preparing, labeling, sending routine and emergency specimens to laboratory; observation and communication skills; routine for verifying doctor's orders and patient's identity; routines for reporting and recording.
2. Slides, filmstrips, films, videotapes, and/or mediated programmed instruction (individual or group) on procedures, techniques, and routines for collecting feces specimen from stool and by glove, sterile swab, and low enema procedures; preparing, labeling, and sending stool specimen for occult blood, ova and parasites, amoeba, and guaiac acid.
3. Hardcover programmed instruction
4. Lecture
5. Demonstration
6. Discussion
7. Practice in simulated patient care unit
8. Study assignments
9. Written exercises

Training Aids

1. Filmstrips/films/videotapes
2. Mediated programmed instruction
3. Hardcover programmed instruction
4. Chalk board
5. Anatomical models

6. Equipment and supplies
7. Instructor's guide
8. Student syllabus
9. References

Examination Modes

1. Response in classroom
2. Paper and pencil test
3. Rating on performance in simulated practice
4. Rating on performance in work situation (feedback)
5. Oral quiz on knowledge related to performance in simulated practice and work situation (feedback)

Training Time

1:00 hour didactic

1:00 hour supervised practice

LEARNING MODULE IF3
SPECIMENS: COLLECTING AND HANDLING OF UPPER
RESPIRATORY TRACT AND EAR SECRETIONS

Tasks

- 150137 Ensure that doctor's orders are carried out
- 110063 Verify identification of the patient, e.g., treatment/medication/
examination
- 120010 Explain/answer patient's questions regarding examination/test/
treatment/procedure
- 120131 Ask patient to collect specimen
- 120132 Check with patient to ensure that he has collected specimen as
instructed
- 150078 Ask patient/check chart for contraindications of treatment,
procedures, tests
- _____ Collect, prepare, label, and send expectorated sputum specimen
to laboratory
- 259006 Collect sputum specimen by suction cup
- 259008 Collect throat, nose, ear cavity specimens by suction cup
- 259007 Take nasal, ear, throat specimen by sterile swab
- 259005 Prepare, label, and send culture specimen to laboratory
- _____ Prepare, label, and send emergency specimens to the laboratory
- 130436 Evaluate patient's complaints or symptoms of pain
- 130382 Observe and record patient's physical and emotional response to
treatment/diagnostic procedure
- 150064 Write nursing notes
- _____ Record on TPR graphic sheet
- _____ Check off on patient care plan

Performance Objective (Stimulus)

When assigned by the senior corpsman/technician, nurse, or doctor to collect a sputum specimen and/or secretions from the upper respiratory tract or ears ordered by the doctor and send to the laboratory.

Performance Objective (Behavior)

The corpsman/technician will verify the specimen to be collected and the patient from whom it is to be collected; explain to the patient the requirement for the specimen and how it is to be collected; recognize any contraindications for the use of suction in collecting the specimens; collect an expectorated sputum specimen and upper respiratory and ear secretion specimen by suction or swab; collect culture specimen from upper respiratory tract and ears; evaluate patient's complaints and reaction to collection procedure; prepare, label, and send specimen to laboratory for routine or emergency examination; and record on nursing notes, TPR graphic sheet and nursing care plan.

Performance Objective (Conditions)

With indirect or selective supervision and without assistance.

Performance Objective (Criteria)

In accordance with established standard procedures, techniques, and routines.

Performance Objective (Consequence)

Specimen of upper respiratory tract and ear secretions sent to laboratory for ordered examinations.

Performance Objective (Next Action)

Follow-up on return of laboratory report.

Knowledge and Skills

1. Anatomy and physiology of upper respiratory tract and ear
2. Procedure for verification of doctor's orders
3. Procedure for verification of patient's identity
4. Purpose of specimen test
5. Patient's disease, therapy, and condition as related to collecting procedure and test
6. Communication techniques for explaining procedure to patient
7. Instructional techniques for teaching patient to collect sputum specimen

8. Procedure and techniques for collecting secretions from upper respiratory tract and ears by suction; for collecting cultured specimens; and for preparing, labeling, and sending routine and emergency specimens to laboratory.
9. Observation techniques for assessing patient's reaction to procedure and complaints
10. Preparation of laboratory request
11. Recording specimen collection and sending to laboratory on nursing notes, TPR graphic sheet, and patient care plan
12. Cleaning and disposal of used equipment and supplies

Instructional Strategies

1. Pretest and/or review on anatomy and physiology of upper respiratory tract and outer ears; preparing, labeling, and sending routine and emergency specimens to the laboratory; observation and communication skills; routine for verifying doctor's orders and patient's identity; routine for reporting and recording.
2. Slides, filmstrips, films, videotapes, and/or mediated programmed instruction (individual or group) on procedures, techniques, and routines for collection of specimens from upper respiratory tract and ear secretions.
3. Hardcover programmed instruction
4. Lecture
5. Demonstration
6. Discussion
7. Practice in simulated patient care unit
8. Study assignments
9. Written exercises

Training Aids

1. Filmstrips/films/videotapes
2. Mediated programmed instruction
3. Hardcover programmed instruction
4. Slides
5. Chalk board
6. Anatomical models
7. Equipment and supplies

8. Instructor's guide
9. Student syllabus
10. References

Examination Modes

1. Response in classroom
2. Paper and pencil test
3. Rating on performance in simulated practice
4. Rating on performance in work situation (feedback)
5. Oral quiz on knowledge related to performance in simulated practice and work situation (feedback)

Training Time

- 1:00 hour didactic
- 1:00 hour supervised practice

LEARNING MODULE IF4
SPECIMENS: COLLECTING AND HANDLING OF DRAINAGE
FROM BODY ORIFICES AND OPEN WOUNDS

Tasks

- 150137 Ensure that doctor's orders are carried out
- 110063 Verify identification of the patient, e.g., treatment/medication/
examination
- 120010 Explain/answer patient's questions regarding examination/test/
treatment/procedure
- 150078 Ask patient/check chart for contraindication of treatment, pro-
cedure, tests
- _____ Collect smear/culture of eye drainage, send to laboratory
- _____ Collect smear/culture of ear drainage, send to laboratory
- _____ Collect smear/culture of urethral drainage, send to laboratory
- _____ Collect smear/culture of throat drainage, send to laboratory
- 259004 Take vaginal smear from patient
- 259009 Take wound specimen from patient
- 259010 Take pus specimen from patient
- 259005 Prepare, label, and send culture specimens to laboratory
- 130436 Evaluate patient's complaints/symptoms of pain
- 130382 Observe and report patient's physical and emotional response to
treatment/diagnostic test
- _____ Prepare, label, and send emergency specimens to the laboratory
- 150064 Write nursing notes
- _____ Record on TPR graphic sheet
- _____ Check off on patient care plan

Performance Objective (Stimulus)

When assigned by the senior corpsman/technician, nurse, or doctor to collect and send drainage specimens ordered by the doctor to the laboratory.

Performance Objective (Behavior)

The corpsman/technician will verify the specimen to be collected and the patient from whom it is to be collected; explain to the patient the requirement

for the specimen and how it is to be collected; recognize any contraindication for the collection procedure; collect, label, and prepare drainage specimen (involving smears and cultures) from the eyes, ears, throat, urethra, vagina, and open wounds; evaluate the patient's complaints and reaction to the procedure; prepare, label, and send the specimens to the laboratory for routine and emergency examination; and record on the nursing notes, TPR graphic sheet, and nursing care plan.

Performance Objective (Conditions)

With selective supervision and without assistance.

Performance Objective (Criteria)

In accordance with established standard procedures, techniques, and routines.

Performance Objective (Consequence)

Drainage specimens from body orifices and open wounds sent to the laboratory for tests ordered by the doctor.

Performance Objective (Next Action)

Follow-up on laboratory reports.

Knowledge and Skills

1. Anatomy and physiology of ears, nose, throat, urethra, and vagina
2. Procedure for verification of doctor's orders
3. Procedure for verification of patient's identity
4. Purpose of the specimen test
5. Patient's disease, therapy, and condition as related to the collecting procedure and test
6. Communication techniques for explaining procedure to patient
7. Procedures and techniques for collecting drainage specimens, including smears and cultures
8. Observation techniques for assessing patient's reaction to procedure and complaints
9. Preparation of laboratory request

10. Recording of specimen collection and sending to laboratory on nursing notes, TPR graphic sheet, and patient care plan
11. Cleaning or disposal of used equipment and supplies

Instructional Strategies

1. Pretest and/or review on anatomy and physiology of eyes, ears, nose, throat, urethra, vagina; collecting culture specimens; preparing, labeling, and sending routine and emergency specimens to the laboratory; observation and communication skills; routine for verifying doctor's orders and patient's identity; routines for reporting and recording.
2. Slides, filmstrips, films, videotapes, and/or mediated programmed instruction (individual or group) on procedures, techniques, and routines for collecting drainage smear specimens from eyes, ears, nose, throat, urethra, and vagina.
3. Hardcover programmed instruction
4. Lecture
5. Demonstration
6. Discussion
7. Practice in simulated patient care unit
8. Study assignments
9. Written exercises

Training Aids

1. Filmstrips/films/videotapes
2. Mediated programmed instruction
3. Hardcover programmed instruction
4. Chalk board
5. Wall charts
6. Anatomical models
7. Equipment and supplies
8. Instructor's guide
9. Student syllabus
10. References

Examination Modes

1. Response in classroom
2. Paper and pencil test
3. Rating on performance in simulated practice
4. Rating on performance in work situation (feedback)
5. Oral quiz on knowledge related to performance in simulated practice and work situation (feedback)

Training Time

0:45 hour didactic

0:45 hour supervised practice

LEARNING MODULE IF5
SPECIMENS: COLLECTING AND HANDLING OF BLOOD

Tasks

- 150137 Ensure that doctor's orders are carried out
- 110063 Verify identification of the patient, e.g., treatment/medication/
examination
- 120010 Explain/answer patient's questions regarding examination/test/
treatment/procedure
- 259042 Collect capillary blood sample, i.e., fingertip/toe, earlobe
- 259025 Collect blood by venipuncture
- 259001 Prepare, label, and send routine specimen, e.g., urine and blood,
to laboratory
- _____ Collect, prepare, label, and send blood specimens to laboratory
for sedimentation rate
- _____ Collect, prepare, label, and send blood specimens to laboratory
for clotting time
- _____ Collect, prepare, label, and send blood specimens to laboratory
for blood chemistry
- 259005 Prepare, label, send culture specimens to laboratory
- _____ Collect, prepare, label, and send blood specimens to laboratory
blood bank for typing and/or cross matching
- _____ Assist with Bromsulphalein test and send specimens to laboratory
- 130436 Evaluate patient's complaints/symptoms of pain
- 130382 Observe and record patient's physical/emotional response to
treatment/diagnostic tests
- 150064 Write nursing notes
- _____ Prepare, label, and send emergency specimens to the laboratory
- _____ Record on TPR graphic sheet
- _____ Check off on patient care plan

Performance Objective (Stimulus)

When assigned by the senior corpsman/technician, nurse, or doctor to collect
a blood specimen ordered by the doctor and send to the laboratory.

Performance Objective (Behavior)

The corpsman/technician will verify the specimen to be collected and the patient from whom it is to be collected; explain to the patient the requirement for the specimen and how it is to be collected; recognize any contraindication for the collection procedure; collect blood specimens from the veins, using the syringe and needle and vacutainer, and from the capillaries, using prick and pipette technique, for routine blood count, blood chemistry; clotting time, sedimentation rate, culture, Bromsulphalein test, and cross matching; prepare, label, and send specimens to the laboratory (blood bank for typing and cross matching) for routine and emergency examination; prepare special request and patient tags for cross matching specimens, and record on nursing notes, TPR graphic sheet, and nursing care plan.

Performance Objective (Conditions)

With supervision and with or without an assistant, depending on patient's condition.

Performance Objective (Criteria)

According to established standard procedure, using the correct collection tubes or slides, and without error in patient identification for typing and cross matching.

Performance Objective (Consequence)

Blood sample sent to laboratory, examination ordered by the doctor.

Performance Objective (Next Action)

Follow-up on laboratory reports.

Knowledge and Skills

1. Anatomy and physiology of the blood vessels
2. Location of veins and capillaries from which blood is drawn
3. Procedure for verification of doctor's orders
4. Procedure for verification of patient's identity

5. Purpose of specimen test
6. Patient's disease, therapy, and condition as related to the collection procedure and test
7. Communication techniques for explaining procedure to patient
8. Procedures and techniques for collecting venous and capillary blood
9. Observation techniques for assessing patient's complaints and reaction to procedure
10. Preparation of laboratory request and typing and cross matching forms
11. Recording of blood collection and test to be performed on nursing notes, graphic TPR sheet, and patient care plan
12. Cleaning and disposal of used equipment and supplies

Instructional Strategies

1. Pretest and/or review on anatomy and physiology of blood vessels and location of veins and capillaries for drawing blood; preparing, labeling, and sending routine and emergency specimens to the laboratory; observation and communication skills; routine for verifying doctor's orders and patient's identity; routines for reporting and recording.
2. Slides, filmstrips, films, videotapes, and/or mediated programmed instruction (individual or group) on procedures, techniques, and routines for drawing blood sample by syringe and needle and vacutainer from veins, and prick with pipette from capillaries; special procedures, techniques, and routines for typing and cross matching.
3. Hardcover programmed instruction
4. Lecture
5. Demonstration
6. Discussion
7. Practice in simulated patient care unit
8. Study assignments
9. Written exercises

Training Aids

1. Filmstrips/films/videotape
2. Mediated programmed instruction
3. Hardcover programmed instruction
4. Chalk board
5. Wall charts

6. Anatomical models
7. Equipment and supplies
8. Instructor's guide
9. Student syllabus
10. References

Examination Modes

1. Response in classroom
2. Paper and pencil test
3. Rating on performance in simulated practice
4. Rating on performance in work situation (feedback)
5. Oral quiz on knowledge related to performance in simulated practice and work situation (feedback)

Training Time

- 1:00 hour didactic
- 1:00 hour supervised practice

LEARNING MODULE IF6

SPECIMENS: COLLECTING AND HANDLING OF SPECIMENS NOT ORDERED

Tasks

- 130388 Observe/record or describe characteristics of urine/feces/vomitus/
regurgitation
- 150014 Collect unordered specimens for nurse/doctor to evaluate
- 120131 Ask patient to collect specimen
- 120132 Check with patient to ensure that he has collected specimen as
instructed
- 150021 Initiate and order diagnostic test
- 150064 Write nursing notes
- _____ Check off on patient care plan
- _____ Record on TPR graphic sheet

Performance Objective (Stimulus)

When patient has urine, stool, sputum, emesis, regurgitation, or drainage
with unusual or abnormal characteristics.

Performance Objective (Behavior)

The corpsman/technician will collect a specimen and save it for the nurse or
doctor to evaluate or send it to the laboratory for examination and record
on nursing notes, TPR graphic sheet, and patient care plan.

Performance Objective (Conditions)

Without supervision or assistance.

Performance Objective (Criteria)

According to established standard procedures, techniques, and routines for
collecting and handling particular specimen.

Performance Objective (Consequence)

Assessment of urine, stool, emesis, regurgitation, or drainage specimens
with unusual or abnormal characteristics.

Performance Objective (Next Action)

Discard specimen, or send to laboratory, or follow-up on return of laboratory reports.

Knowledge and Skills

1. Procedure for verification of patient's identity
2. Patient's disease, therapy, and condition as related to specimen
3. Characteristics of normal and abnormal or unusual urine, stools, sputum, emesis, regurgitation, and drainage from body orifices and open wounds.
4. Observation skills for detecting abnormal or unusual urine, stools, sputum, emesis, etc.
5. Communication skills for explaining to patient and discussing with nurse or doctor
6. Instructional techniques for teaching patient to collect specimen
7. Procedures and techniques for collecting and handling specimen
8. Recording specimen collection and action taken on nursing notes, TPR graphic sheet, and patient care plan
9. Care or disposal of equipment and supplies

Instructional Strategies

1. Pretest and/or review on procedures, techniques, and routines for collecting and handling specimens; observation, communication, and instructional skills; routine for verifying patient's identity; routines for reporting and recording.
2. Slides, filmstrips, films, videotapes, and/or mediated programmed instruction (individual or group) on characteristics of normal urine, stool, sputum, vomitus, drainage from body orifices and wounds, and secretions from upper respiratory tract and ears.
3. Hardcover programmed instruction
4. Lecture
5. Discussion
6. Study assignments
7. Written exercises

Training Aids

1. Filmstrips/films/videotapes
2. Mediated programmed instruction

3. Hardcover programmed instruction
4. Chalk board
5. Instructor's guide
6. Student syllabus
7. References

Examination Modes

1. Response in classroom
2. Paper and pencil test
3. Rating on performance in work situation (feedback)
4. Oral quiz on knowledge related to performance in work situation (feedback)

Training Time

0:30 hour didactic

LEARNING MODULE IF7
SPECIMENS: FOLLOW-UP ON LABORATORY REPORTS

Tasks

- 330208 Arrange for/follow-up completion of laboratory tests
_____ Follow-up on emergency laboratory reports
250048 Look up normal values for laboratory tests from reference tables/books

Performance Objective (Stimulus)

When assigned by the senior corpsman/technician, nurse, or doctor to follow-up on laboratory reports.

Performance Objective (Behavior)

The corpsman/technician will check for overdue reports on routine and emergency specimens and follow-up on their status; receive emergency reports by telephone and record them; recognize abnormal findings on returned reports; and inform the nurse or doctor about status of overdue reports and provide reports of emergency laboratory test, and abnormal findings to them.

Performance Objective (Conditions)

With indirect supervision and without assistance.

Performance Objective (Criteria)

In accordance with time required for routine and emergency laboratory tests; established routine for handling emergency laboratory tests; and abnormal findings.

Performance Objective (Consequence)

Nurse or doctor is informed of status of laboratory tests and results of tests.

Performance Objective (Next Action)

File laboratory reports in patient's chart.

Knowledge and Skills

1. Time required for routine and emergency laboratory work
2. Procedure for receiving emergency reports
3. Procedure for checking due reports
4. Normal range of test results or abnormal findings for urine, feces, upper respiratory secretions, drainage from body orifices and open wounds.
5. Significance of abnormal findings

Instructional Strategies

1. Slides or mediated programmed instruction (individual or group) on normal and abnormal test results and significance of abnormal findings.
2. Hardcover programmed instruction
3. Lecture
4. Discussion
5. Study assignments
6. Written exercises

Training Aids

1. Chalk board
2. Chart of common tests, giving source of specimen, collection technique, normal findings, and common abnormal findings.
3. Instructor's guide
4. Student syllabus
5. References

Examination Modes

1. Response in classroom
2. Paper and pencil test
3. Rating on performance in work situation (feedback)
4. Oral quiz on knowledge related to performance in work situation (feedback)

Training Time

0:30 hour didactic

TRAINING UNIT IG
CARDIOVASCULAR DYSFUNCTIONS: DIAGNOSTIC, THERAPEUTIC,
AND REHABILITATIVE PROCEDURES

Learning Modules

- IG1. Patient's Temperature: Take
- IG2. Patient's Pulse and Respiration: Count and Describe
- IG3. Blood Pressure: Take
- IG4. Venous Pressure: Measure
- IG5. Edema: Examination for and Supportive Treatment
- IG6. Tourniquets in Pulmonary Edema

Training Objective

Upon completion of this training unit the learner must be able to verify the doctor's orders and patient's identity; inform the patient about the procedure or treatment, answer his questions, and reassure him; ascertain any contraindications for the procedure or treatment; collect the necessary equipment and supplies for performing the procedures or treatment; take the patient's temperature, pulse, respirations, blood pressure, and venous pressure; note any abnormalities, and observe any related symptoms; examine patient for edema and give supportive treatment; apply and rotate tourniquets in pulmonary edema; report symptoms and abnormalities to the supervisor and make suggestions for needed changes in patient care; record findings on patient's record and modify nursing care plan to reflect changes in patient care.

The learner must be able to accomplish the foregoing with or without selective supervision and without assistance. He must be able to perform according to established standard procedures, techniques, and routines, obtaining accurate measurements and describing correctly symptoms and abnormalities.

These actions will result in an assessment of patient's temperature, vital signs, venous pressure, and edema and in the administration of supportive treatment of the patient's edema.

Knowledge and Skills

1. Purpose of taking patient's temperature, pulse, respirations, blood pressure, venous pressure, and examination for and giving supportive treatment for edema.
2. Anatomy and physiology of cardiovascular and respiratory systems as related to TPR's, blood pressure, and venous pressure; and the cardiovascular and excretory systems as related to edema.
3. Normal range for temperature, vital signs, and venous pressure
4. Symptoms of abnormalities in body temperature, pulse, respirations, and blood pressure.
5. Communication techniques for giving information to and eliciting it from the patient, reassuring him, and for reporting to supervisory personnel.
6. Observation techniques for assessing patient's condition and response to procedures and treatments.
7. Routine for verifying doctor's orders and patient's identity
8. Patient's diagnosis, therapy, and condition as related to temperature, pulse, respiration, blood pressure, venous pressure, and edema.
9. Procedures, techniques, and routines for taking temperature, pulse, respiration, blood pressure, venous pressure, and for assessing presence and extent of edema and giving supportive treatment; for applying and rotating tourniquets in pulmonary edema; for recording findings on the TPR sheet, other graphic records, nursing notes, and nursing care plan.
10. Routines and techniques for suggesting changes in patient care and for modifying nursing care plan to reflect changes.
11. Routines and procedures for clean-up and care of equipment

Instructional Strategies

1. Pretest and/or review on anatomy and physiology of circulatory, respiratory, and excretory systems; communication and observation skills; routines for verifying doctor's orders and patient's identity; routines for reporting and recording.
2. Slides, filmstrips, films, videotapes, and/or mediated programmed instruction (individual or group) on purposes, procedures, techniques, and routines for taking temperature, pulse, respirations, blood pressure, venous pressure, and recording on TPR sheet and other special graphs and forms; applying and rotating tourniquets in pulmonary edema, checking edema, giving massage to reduce edema, and elevating extremities for edema; symptoms of temperature and vital signs abnormalities; normal ranges for temperature, vital signs, and venous pressure.
3. Hardcover programmed instruction

4. Lecture
5. Discussion
6. Demonstration
7. Practice in simulated patient care unit
8. Study assignments
9. Written exercises

Training Aids

1. Filmstrips/films/videotapes
2. Mediated programmed instruction
3. Hardcover programmed instruction
4. Slides
5. Wall charts
6. Chalk board
7. Anatomical models
8. Equipment and supplies
9. Instructor's guide
10. Student syllabus
11. References

Examination Modes

1. Response in classroom
2. Paper and pencil test
3. Rating on performance in simulated practice
4. Rating on performance in work situation (feedback)
5. Oral quiz on knowledge related to performance in simulated practice and/or work situation (feedback)

Training Time

2:45 hours didactic

2:50 hours supervised practice

LEARNING MODULE IG1
PATIENT'S TEMPERATURE: TAKE

Tasks

- 330328 Cross check medications and treatment card with KARDEX and doctor's orders
- 110063 Verify identification of patient, e.g., for treatments, medications, and examinations
- 120080 Inform patient of procedures prior to/during examination/test/treatment
- 150078 Ask patient/check chart for contraindications for treatment/procedure/test
- 120010 Explain/answer patient's questions regarding examination/test/treatment/procedure
- 120046 Reassure/calm apprehensive/anxious patient
- _____ Wash hands prior to/after patient care, medications, treatments, examinations, procedure, specimen collecting and handling
- _____ Obtain equipment and/or supplies and set up for procedure/treatment/test/examination
- 130014 Check patient's temperature
- _____ Take patient's oral temperature
- _____ Take patient's rectal temperature
- _____ Take patient's axilla temperature
- 130100 Observe patient for signs of chilling
- 130410 Check patient for sweating or diaphoresis
- 130409 Check temperature of skin
- 130382 Observe/record patient's physical/emotional response to treatment/diagnostic procedure
- 150069 Give/receive verbal reports about patient
- 150035 Give report on changes/special care/treatments/tests for patient
- 150013 Make suggestions regarding patient care
- 150082 Suggest changes in patient's nursing care plan
- 150102 Initiate and implement changes in patient's nursing care plan
- _____ Record in TPR book
- 330072 Graph patient data
- 250039 Plot reading/values on rectilinear graph paper
- 150064 Write nursing notes

Performance Objective (Stimulus)

When assigned by the doctor, nurse, or senior corpsman/technician to take a patient's temperature ordered by the physician.

Performance Objective (Behavior)

The corpsman/technician will verify the doctor's orders and patient's identity; wash his hands; prepare the required thermometer and supplies for taking temperatures; inform the patient about the procedure, answer his questions, and, if necessary, reassure him; ascertain any contraindications for taking an oral or rectal temperature; take the oral temperature using an oral clinical or electronic thermometer, the axilla temperature using an oral thermometer, or the rectal temperature using a rectal thermometer; observe the patient for symptoms of chilling and diaphoresis and any untoward reaction to the procedure; if temperature is abnormal, report to the supervisor; if temperature has been normal over extended period of time, suggest discontinuation of frequency of taking it and reflect change on nursing care plan; record the temperature on patient's TPR record and in TPR book and other observations on nursing notes; and clean equipment, replenish tray ready for use.

Performance Objective (Conditions)

Without supervision or assistance.

Performance Objective (Criteria)

In accordance with established standard procedures, routines, and techniques.

Performance Objective (Consequence)

Patient's temperature will be taken, reported, and recorded correctly.

Performance Objective (Next Action)

Next assignment.

Knowledge and Skills

1. Purpose of taking body temperature
2. Anatomy and physiology as related to temperature taking, normal temperature range, and significance of abnormal temperature (fever); symptoms of abnormal body temperature.
3. Communication techniques for giving information to the patient and eliciting it from him, reassuring the patient, and reporting to the supervisor.
4. Observation techniques for assessing general symptoms, such as chilling and sweating, which indicate probable change in body temperature.
5. Patient's diagnosis, therapy, and condition as related to body temperature and frequency for taking.
6. Criteria for determining contraindications for method of taking temperature
7. Precautionary measures relative to temperature taking
8. Verification of patient's identity
9. Procedures, techniques, and routines for taking oral, axilla, and rectal temperatures and recording on the patient's TPR record, other graphic records, and in the temperature book.
10. Criteria for suggesting frequency in taking temperature and action related to modification.
11. Routine, procedures, and techniques for handling clean-up following temperature taking.

Instructional Strategies

1. Pretest and/or review on anatomy and physiology of mouth, axilla, and rectum; communication and observation skills; verification of patient's identity; recording on nursing notes and nursing care plan.
2. Slides, filmstrips, films, videotapes, and/or mediated programmed instruction (individual or group) on purpose, procedure, techniques, and routine for setting up and taking patient's oral, axilla, and rectal temperature and clean-up after procedure; symptoms of change in patient's temperature; contraindications and precautionary measures, especially as related to method; and criteria for suggesting changes in frequency.
3. Hardcover programmed instruction
4. Lecture
5. Discussion
6. Demonstration
7. Practice in simulated patient care unit
8. Study assignments
9. Written exercises

Training Aids

1. Filmstrips/films/videotapes
2. Mediated programmed instruction
3. Hardcover programmed instruction
4. Slides
5. Wall charts
6. Chalk board
7. Anatomical models
8. Equipment and supplies
9. Instructor's guide
10. Student syllabus
11. References

Examination Modes

1. Response in classroom
2. Paper and pencil test
3. Rating on performance in simulated practice
4. Rating on performance in work situation (feedback)
5. Oral quiz on knowledge related to performance in simulated practice and/or work situation (feedback)

Training Time

0:30 hour didactic

0:45 hour supervised practice

LEARNING MODULE IG2

PATIENT'S PULSE AND RESPIRATION: COUNT AND DESCRIBE

Tasks

- 330328 Cross check medications and treatment card with KARDEX and doctor's orders
- 110063 Verify identification of patient, e.g., for treatments, medications, and examinations
- 120080 Inform patient of procedures prior to/during examination/test/treatment
- 150035 Give report on changes/special care/treatments/tests for patient
- 120010 Explain/answer patient's questions regarding examination/test/treatment/procedure
- 120046 Reassure/calm apprehensive/anxious patient
- _____ Wash hands prior to/after patient care, medications, treatments, examinations, procedure, specimen collecting and handling
- 130014 Check patient's pulse
- 130016 Check radial (wrist) pulse
- 130010 Check femoral pulse for presence and quality
- 130011 Check pedal pulse for presence and quality
- 130017 Check apical pulse rate/rhythm with stethoscope
- _____ Observe for/report/symptoms of abnormal pulse
- 130404 Check/count respirations
- 130099 Observe for/report and describe abnormal respirations
- 130407 Check color of skin, e.g., cyanosis, blanching, jaundice, mottling
- 130110 Perform circulation check, e.g., color, pulse, temperature of skin, capillary return
- 150113 Determine need to check vital signs more often/less often than ordered by doctor
- 130382 Observe/record patient's physical/emotional response to treatment/diagnostic procedure
- 150069 Give/receive verbal reports about patient
- 150035 Give report on changes/special care/treatments/tests for patient
- 150013 Make suggestions regarding patient care
- 150082 Suggest changes in patient's nursing care plan
- 150102 Initiate and implement changes in patient's nursing care plan
- _____ Record in TPR book

330072 Graph patient data
250039 Plot reading values on rectilinear graph paper
150064 Write nursing notes

Performance Objective (Stimulus)

When assigned by the doctor, nurse, or senior corpsman/technician to count and describe a patient's pulse and respiration as ordered by the physician.

Performance Objective (Behavior)

The corpsman/technician will verify the doctor's orders, patient's identity; inform the patient that his pulse is to be taken, answer his questions, and give reassurance if indicated; count the pulse and respiration rate and observe for any abnormalities, which, if present, report to the supervisor; and record the counts in the temperature book and on the patient's TPR record, and the abnormalities on the nursing notes. He will suggest change in the frequency of taking pulse and respiration rate, depending on the patient's condition, and reflect these changes in the nursing care plan.

Performance Objective (Conditions)

Without supervision or assistance.

Performance Objective (Criteria)

According to established standard procedures, techniques, and routines.

Performance Objective (Consequence)

Patient's pulse and respiration rate will be taken, reported and recorded, and abnormalities described correctly.

Performance Objective (Next Action)

Next assignment.

Knowledge and Skills

1. Purpose of counting rate and describing pulse and respiration
2. Anatomy and physiology of the circulatory and respiratory systems as related to pulse and respirations; normal pulse and respiration rate range; abnormal pulse and respiration and their significance.
3. Pulse and respirations as a part of the vital signs pattern
4. Communication techniques for giving information to and eliciting it from the patient and for reporting to supervisory personnel.
5. Observation techniques for assessing the patient's condition relative to pulse and respiration abnormalities.
6. Routine for verification of doctor's orders and patient's identity
7. Patient's diagnosis, therapy, and condition as related to frequency and kind of pulse and respirations
8. Criteria for contraindications for taking pulse at certain body locations and for determining need to take pulse and respirations, more or less frequently.
9. Procedures, techniques, and routines for counting and describing pulse and respirations and recording on the patient's TPR record, other graphic records, and nursing notes.
10. Routines and techniques for suggesting changes in patient care and for modifying nursing care plan to reflect changes.
11. Routines and procedures for clean up and care of equipment

Instructional Strategies

1. Pretest and/or review on anatomy and physiology of the circulatory and respiratory systems; communication and observation skills; routine for verifying patient's identity; recording on nursing notes and nursing care plan.
2. Slides, filmstrips, films, videotapes, and/or mediated programmed instruction (individual or group) on purpose, procedure, techniques, and routines for counting and describing patient's pulse and respiration; and criteria for supporting change in frequency of counting them.
3. Hardcover programmed instruction
4. Lecture
5. Discussion
6. Demonstration
7. Practice in simulated patient care unit
8. Study assignments
9. Written exercises

Training Aids

1. Filmstrips/films/videotapes
2. Mediated programmed instruction
3. Hardcover programmed instruction
4. Slides
5. Wall charts
6. Chalk board
7. Anatomical models
8. Equipment and supplies
9. Instructor's guide
10. Student syllabus
11. References

Examination Modes

1. Response in classroom
2. Paper and pencil test
3. Rating on performance in simulated practice
4. Rating on performance in work situation (feedback)
5. Oral quiz on knowledge related to performance in simulated practice and/or work situation (feedback)

Training Time

- 0:30 hour didactic
- 0:15 hour supervised practice

LEARNING MODULE IG3
BLOOD PRESSURE: TAKE

Tasks

- 330328 Cross check medications and treatment card with KARDEN and doctor's orders
- 110063 Verify identification of patient, e.g., for treatments, medications, and examinations
- 120080 Inform patient of procedures prior to/during examination/test/treatment
- 150035 Give report on changes/special care/treatments/tests for patient
- 120010 Explain/answer patient's questions regarding examination/test/treatment/procedure
- 120046 Reassure/calm apprehensive/anxious patient
- _____ Wash hands prior to/after patient care, medications, treatments, examinations, procedure, specimen collecting and handling
- _____ Obtain equipment and/or supplies and set up for procedure/treatment/test/examination
- 130006 Check blood pressure
- 130636 Observe for/report symptoms of hypotension/hypertension
- 150113 Determine need to check vital signs more/less often than ordered by the doctor
- 130382 Observe/record patient's physical/emotional response to treatment/diagnostic procedure
- 150069 Give/receive verbal reports about patient
- 150035 Give report on changes/special care/treatments/tests for patient
- 150013 Make suggestions regarding patient care
- 150082 Suggest changes in patient's nursing care plan
- 150102 Initiate and implement changes in patient's nursing care plan
- _____ Record in TPR book
- 330072 Graph patient data
- 250039 Plot reading values on rectilinear graph paper
- 150064 Write nursing notes

Performance Objective (Stimulus)

When assigned by the doctor, nurse, or senior corpsman/technician to take a patient's blood pressure as ordered by the physician.

Performance Objective (Behavior)

The corpsman/technician will verify the doctor's orders and patient's identity; inform the patient about the procedure, answer his questions, and, if necessary, reassure him; take his blood pressure, observe the patient for any symptoms that would indicate hypertension or hypotension; report abnormal findings to the supervisor; and record the blood pressure on the patient's TPR record, other graphs as indicated, and in the TPR book and the abnormalities on the nursing notes. He will suggest change in the frequency for taking the blood pressure, depending on the patient's condition, and reflect those changes in the nursing care plan.

Performance Objective (Conditions)

Without supervision or assistance.

Performance Objective (Criteria)

According to established standard procedures, techniques, and routines.

Performance Objective (Consequence)

Patient's blood pressure will be taken, reported, and recorded.

Performance Objective (Next Action)

Next assignment.

Knowledge and Skills

1. Purpose of taking blood pressure
2. Anatomy and physiology of the circulatory system and the meaning of systolic, diastolic, and pulse pressures; normal blood pressure ranges and significance of abnormal blood pressure readings.
3. Blood pressure as a part of the vital signs pattern

4. Communication techniques for giving information to and eliciting it from the patient and for reporting to supervisory personnel.
5. Observation techniques for assessing the patient's condition and response to conditions as related to blood pressure, e.g., symptoms of shock, excitement.
6. Routine for verification of doctor's orders and patient's identity
7. Patient's diagnosis, therapy, and condition as related to blood pressure.
8. Criteria for determining need to take blood pressure that has not been ordered by the doctor
9. Procedures, techniques, and routines for taking blood pressure and computing pulse pressure
10. Routines and techniques for suggesting changes in patient care and for modifying nursing care plan to reflect changes.
11. Routines and procedures for clean-up and care of equipment

Instructional Strategies

1. Pretest and/or review on anatomy and physiology of the circulatory system; communication and observation skills; routine for verifying patient's identity; recording on nursing notes and nursing care plan.
2. Slides, filmstrips, films, videotapes, and/or mediated programmed instruction (individual or group) on purpose, procedure, techniques, and routines for taking blood pressure; computing pulse pressure; and criteria for suggesting change in the frequency of taking the blood pressure.
3. Hardcover programmed instruction
4. Lecture
5. Discussion
6. Demonstration
7. Practice in simulated patient care unit
8. Study assignments
9. Written exercises

Training Aids

1. Filmstrips/films/videotapes
2. Mediated programmed instruction
3. Hardcover programmed instruction
4. Slides
5. Wall charts

6. Chalk board
7. Anatomical models
8. Equipment and supplies
9. Instructor's guide
10. Student syllabus
11. References

Examination Modes

1. Response in classroom
2. Paper and pencil test
3. Rating on performance in simulated practice
4. Rating on performance in work situation (feedback)
5. Oral quiz on knowledge related to performance in simulated practice and/or work situation (feedback)

Training Time

- 0:30 hour didactic
- 0:15 hour supervised practice

LEARNING MODULE IG4
VENOUS PRESSURE: MEASURE

Tasks

- 330328 Cross check medications and treatment card with KARDEX and doctor's orders
- 110063 Verify identification of patient, e.g., for treatments, medications, and examinations
- 120080 Inform patient of procedures prior to/during examination/test/treatment
- 120010 Explain/answer patient's questions regarding examination/test/treatment/procedure
- 120091 Explain/answer patient's questions regarding symptoms/disease/treatment
- 150141 Elicit information to ascertain patient's understanding of illness/treatment
- 120046 Reassure/calm apprehensive/anxious patient
- _____ Wash hands prior to/after patient care, medications, treatments, examinations, procedure, specimen collecting and handling
- _____ Obtain equipment and/or supplies and set up for procedure/treatment/test/examination
- 200003 Check instruments and supplies for sterilization indicator
- 130083 Check central venous pressure
- 130436 Evaluate patient's complaints/symptoms of pain
- 130382 Observe/record patient's physical/emotional response to treatment/diagnostic procedure
- 150069 Give/receive verbal reports about patient
- 150035 Give report on changes, special care/treatments/tests for patient
- 150073 Notify medical personnel of treatment needs of patient
- 150036 Inform doctor/nurse of patient's condition, e.g., description of symptoms, injuries, or response
- 150013 Make suggestions regarding patient care
- 150082 Suggest changes in patient's nursing care plan
- 150102 Initiate and implement changes in patient's nursing care plan
- 150064 Write nursing notes
- Record on nursing care plan

Performance Objective (Stimulus)

When assigned by the doctor, nurse, or senior corpsman/technician to perform a venous pressure ordered by the physician.

Performance Objective (Behavior)

The corpsman/technician will verify the doctor's orders and patient's identity; inform the patient about the procedure, answer his questions, and reassure him; wash his hand; obtain the needed equipment and supplies, check for sterility, and set up for the procedure; measure the venous pressure and evaluate the patient's response to the procedure, and any complaints that he has of pain; report to supervisory personnel and record the venous pressure, patient's response to its measurement and his condition, and record on nursing notes and on nursing care plan. If changes in patient's care are indicated, suggest them and modify nursing care plan to reflect changes.

Performance Objective (Conditions)

With selective supervision and without assistance.

Performance Objective (Criteria)

In accordance with established standard procedures, techniques, and routines.

Performance Objective (Consequence)

Prescribed measurement of venous pressure taken, reported, and recorded.

Performance Objective (Next Action)

Make the patient as comfortable as possible.

Knowledge and Skills

1. Purpose of measuring venous pressure
2. Anatomy and physiology of the circulatory system and ranges for normal venous pressure
3. Communication techniques for giving information to and eliciting it from the patient and for reporting to supervisory personnel.
4. Observation techniques for assessing the patient's condition and response to measuring the venous pressure.

5. Routine for verification of doctor's orders and patient's identity.
6. Patient's diagnosis, therapy, and condition as related to venous pressure
7. Procedures, techniques, and routines for measuring venous pressure and recording on the nursing notes and nursing care plan.
8. Precautionary measures relative to entering the vein and reading the manometer
9. Routines and techniques for suggesting changes in patient care and for modifying nursing care plan to reflect changes.
10. Routines and procedures for clean-up and care of equipment

Instructional Strategies

1. Pretest and/or review on anatomy and physiology of the circulatory system; observation and communication skills; sterile technique for entering vein; verification of doctor's orders and patient's identity; routine for recording on nursing notes.
2. Slides, filmstrips, films, videotapes, and/or mediated programmed instruction (individual or group) on purpose, procedure, techniques, and routine for taking venous pressure; normal range of venous pressure.
3. Hardcover programmed instruction
4. Lecture
5. Discussion
6. Demonstration
7. Practice in simulated patient care unit
8. Study assignments
9. Written exercises

Training Aids

1. Filmstrips/films/videotapes
2. Mediated programmed instruction
3. Hardcover programmed instruction
4. Slides
5. Wall charts
6. Chalk board
7. Anatomical models
8. Equipment and supplies

9. Instructor's guide
10. Student syllabus
11. References

Examination Modes

1. Response in classroom
2. Paper and pencil test
3. Rating on performance in simulated practice
4. Rating on performance in work situation (feedback)
5. Oral quiz on knowledge related to performance in simulated practice and/or work situation (feedback)

Training Time

- 0:30 hour didactic
- 0:30 hour supervised practice

LEARNING MODULE IG5

EDEMA: EXAMINATION FOR AND SUPPORTIVE TREATMENT

Tasks

- 330328 Cross check medications and treatment card with KARDEX and doctor's orders
- 110063 Verify identification of patient, e.g., for treatments, medications, and examinations
- 120080 Inform patient of procedures prior to/during examination/test/treatment
- 150078 Ask patient/check chart for contraindications for treatment/procedure/test
- 120010 Explain/answer patient's questions regarding examination/test/treatment/procedure/test
- 120091 Explain/answer patient's questions regarding symptoms/disease/treatment
- 150141 Elicit information to ascertain patient's understanding of illness/treatment
- 120046 Reassure/calm apprehensive/anxious patient
- 130436 Evaluate patient's complaints/symptoms of pain
- 130240 Check for edema (swelling) of extremities and eyes
- 130415 Check for pitting edema
- 130084 Measure/weigh patient or personnel
- 110124 Position extremities to reduce swelling or bleeding
- 140396 Give massage to reduce edema
- 130382 Observe/record patient's physical/emotional response to treatment/diagnostic procedure
- 150069 Give/receive verbal reports about patient
- 150035 Give report on changes/special care/treatments/tests for patient
- 150073 Notify medical personnel of treatment needs of patient
- 150036 Inform doctor/nurse of patient's condition, e.g., description of symptoms, injuries or response
- 150013 Make suggestions regarding patient care
- 150082 Suggest changes in patient's nursing care plan
- 150102 Initiate and implement changes in patient's nursing care plan
- 150064 Write nursing notes

_____ Record on nursing care plan
330072 Graph patient data

Performance Objective (Stimulus)

When assigned by the doctor, nurse, or senior corpsman/technician to check patient's edema and to give supportive care as prescribed by the physician.

Performance Objective (Behavior)

The corpsman/technician will verify the doctor's orders and patient's identity; inform the patient about the procedure; answer his questions, and reassure; ascertain any contraindications for the procedure; check for edema, the extent of the edema, and change in weight; give massage to reduce edema and position extremities to facilitate venous blood flow; evaluate patient's condition and response to procedure; and inform supervisor (if indicated) and record on nursing notes, nursing care plan, and weight graphic sheet. He will suggest changes in patient care, as indicated, and modify nursing care plan to reflect the changes.

Performance Objective (Conditions)

Without supervision and with or without assistance, depending on the patient's condition.

Performance Objective (Criteria)

In accordance with established standard procedures, techniques, and routines.

Performance Objective (Consequence)

Assessment of patient's edema and administration of supportive care.

Performance Objective (Next Action)

Make the patient as comfortable as possible.

Knowledge and Skills

1. Purpose of examination of status of patient's edema; massage, and elevation of extremities
2. Anatomy and physiology of circulatory and excretory systems as related to edema; how fluids collect in the tissue
3. Communication techniques for giving information to and eliciting it from the patient and for reporting to supervisory personnel.
4. Observation techniques for assessing the patient's condition and response to supportive treatment of massage and elevation of extremities.
5. Routine for verification of doctor's orders and patient's identity.
6. Patient's diagnosis, therapy, and condition as related to edema and anticipated results of massage and elevation of extremities.
7. Criteria for contraindications for weighing patient and giving massage for edema
8. Procedures, techniques, and routines for examining for edema, giving massage for edema, and elevating edematous extremities.
9. Precautionary measures relative to weighing, massage, and elevation of extremities
10. Routines and techniques for suggesting changes in patient care and for modifying nursing care plan to reflect changes.
11. Routines and procedures for clean-up and care of equipment

Instructional Strategies

1. Pretest and/or review on anatomy and physiology of circulatory system, excretory system, and tissues; observation and communication skills; verification of doctor's orders and patient's identity; routines for recording and reporting.
2. Slides, filmstrips, films, videotapes, and/or mediated programmed instruction (individual or group) on purpose, procedures, techniques, and routines for assessing presence and extent of edema; giving massage for edema and elevating edematous extremities.
3. Hardcover programmed instruction
4. Lecture
5. Discussion
6. Demonstration
7. Practice in simulated patient care unit
8. Study assignments
9. Written exercises

Training Aids

1. Filmstrips/films/videotapes
2. Mediated programmed instruction
3. Hardcover programmed instruction
4. Slides
5. Wall charts
6. Chalk board
7. Anatomical models
8. Equipment and supplies
9. Instructor's guide
10. Student syllabus
11. References

Examination Modes

1. Response in classroom
2. Paper and pencil test
3. Rating on performance in simulated practice
4. Rating on performance in work situation (feedback)
5. Oral quiz on knowledge related to performance in simulated practice and/or work situation (feedback)

Training Time

- 0:30 hour didactic
- 0:45 hour supervised practice

LEARNING MODULE IG6
TOURNIQUETS IN PULMONARY EDEMA

Tasks

- 330328 Cross check medications and treatment card with KARDEX and doctor's orders
- 110063 Verify identification of patient, e.g., for treatments, medications, and examinations
- 120080 Inform patient of procedures prior to/during examination/test/treatment
- 120010 Explain/answer patient's questions regarding examination/test/treatment/procedure
- 120091 Explain/answer patient's questions regarding symptoms/disease/treatment
- 150141 Elicit information to ascertain patient's understanding of illness/treatment
- 120046 Reassure/calm apprehensive/anxious patient
- 140163 Rotate tourniquets
- 130436 Evaluate patient's complaints/symptoms of pain
- 130382 Observe/record patient's physical/emotional response to treatment/diagnostic procedure
- 150069 Give/receive verbal reports about patient
- 150035 Give report on changes/special care/treatments/tests for patient
- 150013 Make suggestions regarding patient care
- 150082 Suggest changes in patient's nursing care plan
- 150102 Initiate and implement changes in patient's nursing care plan
- 150064 Write nursing notes
- _____ Record on patient (nursing) care plan

Performance Objective (Stimulus)

When assigned by the doctor, nurse, or senior corpsman/technician to apply and rotate tourniquets for relief of pulmonary edema.

Performance Objective (Behavior)

The corpsman/technician will verify the doctor's orders and patient's identity; inform the patient about the procedure, answer his questions and reassure him; collect the four tourniquets or Danzer apparatus and carry to bedside; drape the patient; apply the tourniquets or apparatus and release in order, according to scheduled time; evaluate the patient's response to the procedure; if indicated, suggest changes in care and modify nursing care plan accordingly; report to supervisory personnel, if indicated, and record on nursing notes and nursing care plan.

Performance Objective (Conditions)

Without supervision or assistance.

Performance Objective (Criteria)

According to established standard procedures, techniques, and routines.

Performance Objective (Consequence)

Patient's periplural circulation will be slowed down reducing strain and volume of blood to the lungs and heart.

Performance Objective (Next Action)

Make patient as comfortable as possible.

Knowledge and Skills

1. Purpose of tourniquets in pulmonary edema (bloodless phlebotomy)
2. Anatomy and physiology of circulatory system
3. Communication techniques for giving information to and eliciting it from the patient and for reporting to supervisory personnel.
4. Observation techniques for assessing the patient's condition and response to the bloodless phlebotomy.
5. Routine for verification of doctor's orders and patient's identity
6. Patient's diagnosis, therapy, and condition as related to the use of tourniquets to reduce edema.
7. Procedures, techniques, and routines for applying and rotating the tourniquets or Danzer apparatus and recording on the nursing notes and nursing care plan.

8. Precautionary measures relative to tightness of the tourniquets and timing of the rotation
9. Routines and techniques for suggesting changes in patient care plan and for modifying nursing care plan to reflect changes.
10. Routines and procedures for clean-up and care of equipment

Instructional Strategies

1. Pretest and/or review on routines for verifying doctor's orders and patient's identity; communication and observation skills; anatomy and physiology of circulatory system; routines for reporting and recording.
2. Slides, filmstrips, films, videotapes, and/or mediated programmed instruction (individual or group) on procedure, techniques, and routines for applying and rotating tourniquets or Danzer apparatus for relief of pulmonary edema.
3. Hardcover programmed instruction
4. Lecture
5. Discussion
6. Demonstration
7. Practice in simulated patient care unit
8. Practice in work situation
9. Study assignments
10. Written exercises

Training Aids

1. Filmstrips/films/videotapes
2. Mediated programmed instruction
3. Hardcover programmed instruction
4. Slides
5. Wall charts
6. Chalk board
7. Anatomical models
8. Equipment and supplies
9. Instructor's guide
10. Student syllabus
11. References

Examination Modes

1. Response in classroom
2. Paper and pencil test
3. Rating on performance in simulated practice
4. Rating on performance in work situation (feedback)
5. Oral quiz on knowledge related to performance in simulated practice and/or work situation (feedback)

Training Time

0:15 hour didactic

0:20 hour supervised practice

TRAINING UNIT 1H
DRUG THERAPY AND ADMINISTRATION OF MEDICATIONS

Learning Modules

- IH1. Drugs: Information, Controlling Laws, and Policies
- IH2. Drugs: Patient Response and Care
- IH3. Drugs: Maintenance and Security on Patient Care Unit
- IH4. Drugs: Ordering from the Pharmacy
- IH5. Transcription of Doctor's Orders
- IH6. Drugs: Dosage Calculation and Measurement
- IH7. Medications: Administration of Oral
- IH8. Medications: Administration of Topical
- IH9. Medications: Administration by Instillation and Insertion
- IH10. Medications: Administration of Subcutaneous and Intramuscular
- IH11. Medications: Administration of Intravenous
- IH12. Medications: Administration of Inoculations, Vaccinations, and Skin Tests
- IH13. Medications: Instruction to Patient for Self-Administration

Training Objective

Upon completion of this training unit the learner must be familiar with resources for drug information and control; be able to maintain drug storage on the patient care unit and order drugs from the pharmacy; check for out-dated and deteriorated drugs; transcribe doctor's orders; check on medications or the need for prn medication orders; ascertain that the giving of the medication is not contraindicated; verify the medication order and the patient's identity; interpret the medication orders; compute dosage and measure medications; prepare and administer medications orally, topically, by instillation and insertion, intradermally, subcutaneously, intramuscularly, and intravenously; observe the patient's response to the administered drug and take required action in case of untoward effect of drug; record administered medication on patient's record and nursing care plan; clean up the medication area after use; and carry out security routines and procedures for drugs.

The learner must be able to accomplish the foregoing with indirect or selective supervision; however, in some instances, he will require supervision. He will perform with or without assistance, depending upon the patient's condition.

He must be able to perform according to established policies, instructions, rules and regulations, standard procedures, techniques, and routines and without error in administering medications.

These actions will result in the maintenance and security of an adequate drug supply on the patient care unit; the administration of drugs as prescribed by the physician; the recording of administered drugs and the patient's response to them; and the maintenance of a clean and neat drug dispensing environment on the patient care unit.

Knowledge and Skills

1. *Use of references for obtaining information on drugs and control of drugs*
2. Types of pharmaceutical preparations; kinds of drug action; generic and trade names, dosage, routes of administration, precautions for administration, purpose, effect, side effects, untoward effects, contraindications and patient care for commonly prescribed drugs.
3. Observation techniques for assessing patient's condition and response to drug therapy
4. Communication techniques for giving information to and eliciting it from patients and staff members
5. Instructional techniques for teaching patient and family administration of drugs
6. Calculation of dosage and measurement of medication
7. Transcription and interpretation of doctor's orders for drugs
8. Criteria for identifying deteriorated and outdated drugs
9. Policies and procedures governing use of narcotics and controlled drugs
10. Routines for verification of medication orders and patient's identity
11. Anatomy and physiology as related to drug administration
12. Procedures, techniques, and routines for administering drugs by the oral, topical, intradermal, subcutaneous, intramuscular, and intravenous routes and by instillation and insertion.

AD-A085 706

TECHNOMICS INC OAKTON VA

A SYSTEM APPROACH TO NAVY MEDICAL EDUCATION AND TRAINING. APPEN--ETC (11)

F/S S/S

AUG 74

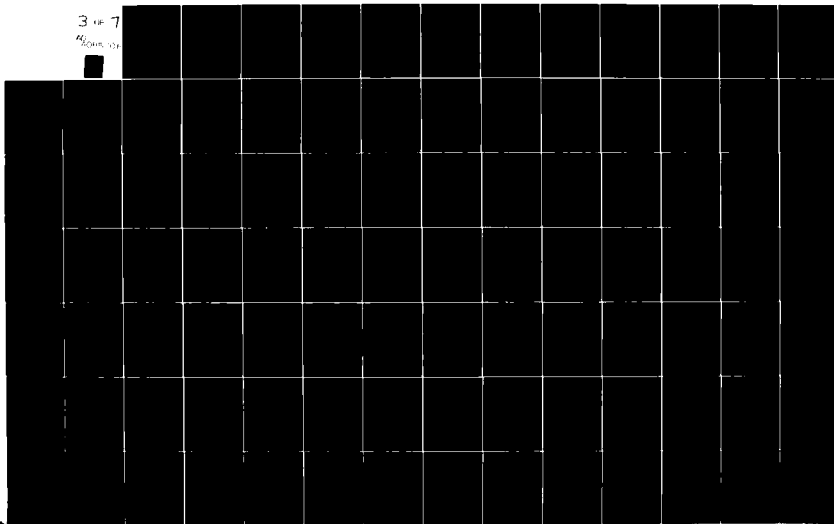
N00014-69-C-0246

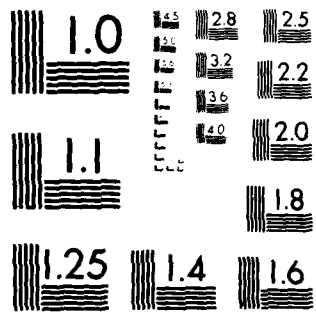
AL

UNCLASSIFIED

3 OF 7

AL
50000000





MICROCOPY RESOLUTION TEST CHART
NATIONAL BUREAU OF STANDARDS-1963-A

13. Routines, procedures, and techniques for recording administered drugs
14. Routines, procedures, and techniques for ordering drugs, maintenance, storage, and security of drugs
15. Routines, procedures, and techniques for maintenance of drug dispensing space, equipment, and supplies

Instructional Strategies

1. Pretest and/or review on anatomy and physiology of respiratory, cardiovascular, digestive, and excretory systems, subcutaneous and muscle tissue, and blood vessels; vena puncture; communication, observation and teaching skills; routines for reporting and recording; systems of measurement and related mathematics.
2. Slides, filmstrips, films, videotapes, and/or mediated programmed instruction (individual or group) on common drugs and their dosage, routines of administration and precautions in giving, effect, side effects, untoward effects and related patient care; drug storage, including location, quantity, and disposition due to deterioration and age; inventorying for required drugs and preparation of pharmacy orders; procedures, techniques, and routines for transcribing doctor's orders; calculating and measuring dosage; administering oral, topical, intradermal, subcutaneous, intramuscular, intravenous drugs and instilling and inserting medications; and teaching patient self-administration.
3. Hardcover programmed instruction
4. Lecture
5. Discussion
6. Demonstration
7. Role playing
8. Practice in simulated patient care unit
9. Study assignments
10. Written exercises
11. Problem solving situations

Training Aids

1. Filmstrips/films/videotapes
2. Mediated programmed instruction
3. Hardcover programmed instruction
4. Slides
5. Wall charts

6. Chalk board
7. Anatomical models
8. Equipment and supplies
9. Instructor's guide
10. Student syllabus
11. References

Examination Modes

1. Response in classroom
2. Paper and pencil test
3. Rating on performance in simulated practice
4. Rating on performance in work situation (feedback)
5. Oral quiz on knowledge related to performance in simulated practice and work situation (feedback)

Training Time

31:15 hours didactic

8:00 hours supervised practice

LEARNING MODULE IH1
DRUGS: INFORMATION, CONTROLLING LAWS, AND POLICIES

Tasks

- 240079 Read and use pharmaceutical manuals
_____ Seek information on new drugs
- 240090 Determine similarities between pharmaceutical trade name and generic names
_____ Read and use laws, policies, instructions, rules, and regulations governing drugs

Performance Objective (Stimulus)

When assigned by the senior corpsman/technician, nurse, or doctor to give medications.

Performance Objective (Behavior)

The corpsman/technician will be familiar with resource materials that provide information about drugs and that govern their use and control.

Performance Objective (Conditions)

With indirect supervision and without assistance.

Performance Objective (Criteria)

He will find the correct drug information without difficulty.

Performance Objective (Consequence)

This action will result in the corpsman/technician being able to find needed drug information.

Performance Objective (Next Action)

The next action is to use the resource information as required in the administration of medications.

Knowledge and Skills

1. Standard pharmaceutical reference manuals: The Pharmacopoeia of the United States (USP); The National Formulary (NF), Local Formulary; New Drugs by American Medical Association; Physicians Desk Reference (PDR); Merck's Manual.
2. Drug companies' publications, brochures, etc.
3. Laws: Harrison Narcotic Law; Federal Food, Drug and Cosmetic Act; state laws, etc.; and their application in federal activities.
4. Department of Defense, Navy Medical Department and local policies, instructions, rules, and regulations governing the control of drugs.
5. System for controlling narcotics and other specified drugs

Instructional Strategies

1. Slides, filmstrips, films, videotapes, and/or mediated programmed instruction (individual or group) on display of reference materials and how to use them.
2. Hardcover programmed instruction
3. Lecture
4. Discussion
5. Demonstration
6. Practice in simulated patient care unit when giving medications
7. Study assignments
8. Written exercises

Training Aids

1. Filmstrips/films/videotapes
2. Mediated programmed instruction
3. Hardcover programmed instruction
4. Chalk board
5. Reference materials, such as USP, NF, PDR, Manual of Medical Department; records for controlling narcotics and other specified drugs.
6. Instructor's guide
7. Student syllabus
8. References

Examination Modes

1. Response in classroom
2. Paper and pencil test
3. Rating on performance in simulated practice
4. Rating on performance in work situation (feedback)
5. Oral quiz on knowledge related to performance in simulated practice and work situation (feedback)

Training Time

1:00 hour didactic

LEARNING MODULE IH2
DRUGS: PATIENT RESPONSE AND CARE

Tasks

- 150063 Talk with patient to ascertain needs and problems
- 150078 Ask patient/check chart for contraindications for treatment, procedure, or test
- 130436 Evaluate patient's complaints or symptoms of pain
- 130610 Assess patient's response to medications/drug therapy
- 130097 Observe, report, and record side effects of treatment/medication
_____ Observe, report, and record untoward effect of drug on patient
- 130590 Observe, report, and record symptoms of drug dependency, e.g., frequent request for pain medication
- 130255 Observe for/report symptoms of insulin shock
- 130589 Observe for and report symptoms of drug abuse, e.g., acid, speed
- 160073 Notify medical personnel of patient's needs
- 150036 Inform nurse/doctor of patient's condition
- 150069 Give and receive verbal reports about patients
- 240127 Answer inquiries regarding drug reaction
- 140461 Give emergency treatment/first aid for insulin shock
- 150064 Write nursing notes
- 330143 Place special treatment tags over/on beds, e.g., fasting, force fluids

Performance Objective (Stimulus)

When assigned by the senior corpsman/technician, nurse, or doctor the responsibility for a patient who is receiving medications.

Performance Objective (Behavior)

The corpsman/technician will observe the patient and communicate with him about his symptoms and complaints relative to medications or drug therapy; assess the drug's effect, side effect, and/or untoward effect and symptoms of drug dependency or abuse; give and/or assist in giving emergency care for untoward effect; report significant symptoms of patient's response to drug to nurse or doctor; record on nursing notes; and tag patient's bed when medication is contraindicated.

Performance Objective (Conditions)

With selective supervision and without assistance.

Performance Objective (Criteria)

Corpsman/technician will make accurate observations on the patient's response to drug therapy and, when necessary, take the proper emergency measures.

Performance Objective (Consequence)

This action will result in correct assessment and care of patient receiving drug therapy.

Performance Objective (Next Action)

The next action is a continuation of the observation and assessment of the patient.

Knowledge and Skills

1. Purpose of medication/drug: treat disease, promote health, aid in diagnosis, relieve symptoms
2. Types of pharmaceutical preparations: aqueous solutions, syrups, spirits, elixirs, capsules, tablets, ointments, suppositories, etc.
3. Definition--drug effectiveness, side effects, untoward effect
4. Kinds of drug action--local, systemic
5. Generic and trade name, dosage, route of administration, precautions of administration, effect, side effects, untoward effects, and patient care for commonly prescribed drugs, such as shown in the following categories

Antibiotics: procaine penicillin, ampicillin, penicillin V, tetracycline, erythromycin, keflin, streptomycin sulfate, chloromycetin.

Chemotherapeutic: sulfisoxazole, gantanol, chloroquine-primaquine phosphate, pavan.

Respiratory System: codeine sulfate, robatussin, ephedrine, epinephrine, aminophylline, tedral.

Central Nervous System: phenobarbital, nembutal, seconal, dilantin, tridione, morphine sulfate, demerol, codeine sulfate, aspirin, tylenol, indocin, fiorinal, darvon, robaxin, parafon forte, thorazine,

compazine, librium, meproamate, valium, elavil, chlorotrimeton, benadryl, phenergin, ornade-actified, dextroamphetamine sulfate.

Gastrointestinal Tract: maalox, mineral oil, colase, metamucil, senakat, kaopectate, camphorated tincture of opium, donnatol, probanthine, atropine sulfate.

Urinary Tract: furadantin, sulfisoxazole, gantanol, pyridium, diuril, esidrix, hydrodiuril.

Cardiovascular System: digitalis, digoxin, atropine sulfate, epinephrine, pronestyl, quinidine sulfate, nitroglycerine, isordil, reserpine, aldomat, ferrous sulfate, vitamin B₁₂, folic acid, gelfoam, hykinone coumadin, sodium heparin.

Endocrine System: prednisone, thryoid, regular insulin, N.P.H. insulin, P2I insulin, orinase.

External (Skin): fostex cream/soap, phenolated calomine lotion, methyl salicylate, theoleroma oil, vaseline, vitamin A and D ointment, betadine, zepharin, alcohol, phisohex, vioform cream, furacin, fulvicin, neomycin ointment, bacitracin ointment, hydrocortisone acetate ointment.

6. Observation techniques for assessing response to drug therapy
7. Emergency and first aid for untoward effect such as insulin reaction
8. Reporting patient's response to drug therapy
9. Recording patient's response to drug therapy

Instructional Strategies

1. Pretest and/or review on anatomy and physiology as related to drug therapy; observation and communication skills; routines for reporting and recording.
2. Slides, filmstrips, films, videotapes, and/or mediated programmed instruction (individual or group) on common drugs--dosage, routes of administration, and precautions in giving, drug effect, side effects, untoward effects, and related patient care.
3. Hardcover programmed instruction: all knowledge and skills
4. Lecture
5. Discussion
6. Demonstration
7. Practice in simulated patient care unit--knowledge about drug ordered for administration

8. Study assignments
9. Written exercises
10. Problem solving situations

Training Aids

1. Filmstrips/films/videotapes
2. Mediated programmed instruction
3. Hardcover programmed instruction
4. Slides
5. Chalk board
6. Drug chart giving type of drug, generic and trade names, dosage range, administration route, effect, side effects, untoward effects, and emergency measures for reaction.
7. Instructor's guide
8. Student syllabus
9. References

Examination Modes

1. Response in classroom
2. Paper and pencil test
3. Rating on performance in simulated practice--knowledge about drug ordered for administration
4. Rating on performance in work situation (feedback)
5. Oral quiz on knowledge related to performance in simulated practice and work situation (feedback)

Training Time

20:00 hours didactic

LEARNING MODULE IH3

DRUGS: MAINTENANCE AND SECURITY ON PATIENT CARE UNIT

Tasks

- 230254 Do supply inventory
- 240129 Check drugs for supply needs
- 230255 Rotate inventory
- 240032 Monitor shelf life and expiration date of drugs/medications
- 240097 Determine expiration date of locally prepared or compounded drugs
- 240168 Check drugs for visible contamination/deterioration, e.g., cloudiness, color change
- 230043 Inspect supplies/equipment for acceptability/damage/loss/pilferage
- 220255 Inspect that supplies/material/equipment are stored properly
- 220123 Store supplies
- 240085 Clarify and store drugs
- 230032 Dispose of supplies
- 330166 Prepare reports for return of damaged supplies
- 330542 Account for keys
- 240084 Safeguard poisons

Performance Objective (Stimulus)

When assigned by the senior corpsman/technician, nurse, or doctor for the maintenance and security of drugs within a patient care unit.

Performance Objective (Behavior)

The corpsman/technician will maintain an adequate supply of required drugs; dispose of outdated, deteriorated, and not required drugs; maintain security of all drugs.

Performance Objective (Conditions)

With indirect supervision and without assistance.

Performance Objective (Criteria)

In accordance with law, policies, and established practice.

Performance Objective (Consequence)

This action will result in adequate supply of usable drugs properly stored and secured.

Performance Objective (Next Action)

The next action is to order the required amount of prescribed drugs for the maintenance of an adequate supply.

Knowledge and Skills

1. Arrangement of drugs in medicine cabinet or lockers: internal, external, poisons, injections, narcotics and other controlled drugs, drugs deteriorated by light, drugs requiring refrigeration, etc.
2. Safeguarding drugs--medication cabinet or locker is locked and key assigned to one person; narcotics and controlled drugs locked and the nurse controls the key.
3. Identification of deteriorated and outdated drugs
4. Disposition of deteriorated and outdated drugs
5. Policy governing labeling of drugs
6. Inventorying drugs and determining order requirements

Instructional Strategies

1. Pretest and/or review on observation and communication skills; routines for reporting and recording
2. Slides, filmstrips, films, videotapes, and/or mediated programmed instruction (individual or group) on drug storage; location of storage; quantity maintained; disposition due to deterioration and age.
3. Hardcover programmed instruction
4. Lecture
5. Discussion
6. Study assignments
7. Written exercises

Training Aids

1. Filmstrips/films/videotapes
2. Mediated programmed instruction
3. Hardcover programmed instruction
4. Slides
5. Chalk board
6. Equipment and supplies
7. Instructor's guide
8. Student syllabus
9. References

Examination Modes

1. Response in classroom
2. Paper and pencil test
3. Rating on performance in simulated practice--when giving medications
4. Rating on performance in work situation (feedback)
5. Oral quiz on knowledge related to performance in simulated practice and work situation (feedback)

Training Time

1:00 hour didactic

LEARNING MODULE IH4
DRUGS: ORDERING FROM THE PHARMACY

Tasks

- 150050 Review doctor's orders and instructions with doctor
- 320328 Cross check medication and treatment card with KARDEX and doctor's orders
- 230254 Do supply inventory
- 240129 Check drugs for supply needs
- 300318 Prepare requisition for supplies
- 230159 Verify/sign off requisition/receipts for supplies/equipment/material
- 250154 Check prescription for completeness, patient's name, doctor's signature, etc.

Performance Objective (Stimulus)

When assigned by the senior corpsman/technician, nurse, or doctor to order drugs from the pharmacy.

Performance Objective (Behavior)

The corpsman/technician will determine the required drugs, the unit, and the quantity of each drug to be ordered; and prepare and send the necessary requisition for obtaining the drug to the pharmacy.

Performance Objective (Conditions)

With indirect supervision and without assistance.

Performance Objective (Criteria)

In accordance with laws, policies, and established standard procedures, techniques, and routines.

Performance Objective (Consequence)

This action will result in a prepared pharmacy order to meet the needs of the patient care unit for a designated time period.

Performance Objective (Next Action)

The next action is to receive and store the ordered drugs.

Knowledge and Skills

1. Inventorying drugs and determining need for replenishment
2. Assessment of new medication and treatment cards, doctor's orders, and nursing care plan for determining need for drug not in stock.
3. Procedures and techniques for preparing orders for routine and emergency drug delivery and for special and controlled drugs.

Instructional Strategies

1. Pretest and/or review on observation and communication skills; routines for reporting and recording.
2. Slides, filmstrips, films, videotapes, and/or mediated programmed instruction (individual or group) on inventorying for required drugs and preparation of pharmacy orders.
3. Hardcover programmed instruction
4. Lecture
5. Discussion
6. Demonstration
7. Practice in simulated patient care unit
8. Study assignments
9. Written exercises

Training Aids

1. Filmstrips/films/videotapes
2. Mediated programmed instruction
3. Hardcover programmed instruction
4. Slides
5. Chalk board
6. Equipment and supplies
7. Instructor's guide
8. Student syllabus
9. References

Examination Modes

1. Response in classroom
2. Paper and pencil test
3. Rating on performance in simulated practice
4. Rating on performance in work situation (feedback)
5. Oral quiz on knowledge related to performance in simulated practice and work situation (feedback)

Training Time

- 0:30 hour didactic
- 0:30 hour supervised practice

LEARNING MODULE IH5
TRANSCRIPTION OF DOCTOR'S ORDERS

Tasks

- 150050 Review doctor's orders and instructions with doctor
- 150054 Obtain clarification of conflicting doctor's orders
- 240172 Notify doctor of errors in medication orders
- 330475 Transcribe physician's orders
- 150061 Verify completeness of doctor's orders, e.g., for all routine admission and pre-op orders
- 320328 Cross check medication and treatment card with KARDEX and doctor's order sheet
- 240154 Check prescription for completeness, patient's name, doctor's signature, etc.

Performance Objective (Stimulus)

When assigned by the senior corpsman/technician, nurse, or doctor to transcribe doctor's orders.

Performance Objective (Behavior)

The corpsman/technician will review the doctor's orders for completeness, correctness, and clarity; discuss with the physician orders that are not clear, complete, and current; transcribe the doctor's orders onto medication and treatment card and patient care plan; and check completed transcriptions; check prescription forms.

Performance Objective (Conditions)

With indirect supervision and without assistance.

Performance Objective (Criteria)

In accordance with established standard procedures, techniques, and routines.

Performance Objective (Consequence)

This action will result in the doctor's orders being transcribed from the doctor's order sheet to medication and treatment cards and nursing care plans without error.

Performance Objective (Next Action)

The next action is to place the medication and treatment cards on the medication board.

Knowledge and Skills

1. Doctor's Order Sheet: purpose, use, content
2. Nursing Care Plan (KARDEX): purpose, use, content
3. Medication Cards: purpose, use, content, filing on medication board
4. Medication Board: description, location, use
5. Prescription Form: purpose, preparation, content
6. Abbreviations and symbols commonly used in doctor's orders

amp.	p.r.n.	tab.
h or s.c.	q h	sol.
I.M.	q 2 h	U.
I.V.	q 3 h	Rx
p.o.	q 4 h	Sig.
p.r.	q 6 h	\bar{c}
ad lib.	q.i.d.	\bar{s}
a.c.	S.O.S.	\overline{ss}
b.i.d.	stat.	\overline{aa}
h.s.	t.i.d.	\mathfrak{J}
q.d. (o.d.)	Cap.	\mathfrak{J}
p.c.	gtt.	others

7. Procedure for transcribing orders onto medication cards, nursing care plans, and other records/requests.
8. Procedure for cross checking orders

Instructional Strategies

1. Pretest and/or review on observation and communication skills; routines for reporting and recording
2. Slides, filmstrips, films, videotapes, and/or mediated programmed instruction (individual or group) on procedures, techniques, and routines for transcribing doctor's orders.

3. Hardcover programmed instruction
4. Lecture
5. Demonstration
6. Discussion
7. Practice in transcribing
8. Study assignments
9. Written exercises

Training Aids

1. Filmstrips/films/videotapes
2. Mediated programmed instruction
3. Hardcover programmed instruction
4. Slides
5. Chalk board
6. Supplies for transcription
7. Instructor's guide
8. Student syllabus
9. References

Examination Modes

1. Response in classroom
2. Paper and pencil test
3. Rating on performance in transcription practice
4. Rating on performance in work situation (feedback)
5. Oral quiz on knowledge related to performance in simulated practice and work situation (feedback)

Training Time

- 0:30 hour didactic
- 0:45 hour supervised practice

LEARNING MODULE IH6
DRUGS: DOSAGE CALCULATION AND MEASUREMENT

Tasks

- 340401 Perform math calculations
- 240169 Convert prescribed dose into units of administration, e.g., number of cc, tablets, etc.
- 240002 Convert common weights and measures from one system to another, e.g., cc to tps., lbs. to kgms.
- 240001 Convert medication dosage from cc to minims, grains to grams
- 240179 Calculate dosage of diagnostic pharmaceuticals, e.g., BSP dye
- _____ Calculate amount of dosage
- _____ Measure amount of medication to be given

Performance Objective (Stimulus)

When assigned by the senior corpsman/technician, nurse, or doctor to give medications.

Performance Objective (Behavior)

The corpsman/technician will compute the dosage of a medication, using the correct mathematical formula, and measure the dosage.

Performance Objective (Conditions)

With selective supervision and without assistance.

Performance Objective (Criteria)

He will perform all computations and measurements without error.

Performance Objective (Consequence)

This action will result in the measurement of the correct dosage.

Performance Objective (Next Action)

The next action is to prepare and administer the drug.

Knowledge and Skills

1. Basic mathematical computations of addition, subtraction, multiplication, division, fractions, decimals, conversion fractions and decimals, percentage, and ratio.
2. Pharmaceutical measurement systems: metric, apothecary, household
3. Recognition of computation errors
4. Compute usage from one strength to another, units for measurement, percentage strength, child's dose.
5. Use conversion tables
6. Convert from one measurement system to another
7. Kinds and use of measuring equipment: medicine glasses, medicine droppers, syringes, flasks, spoons, cups, etc.

Instructional Strategies

1. Pretest and/or review on basic mathematical computation: addition, subtraction, multiplication, division, ratios, and handling of fractions and percentage.
2. Hardcover programmed mathematics course on review material listed above
3. Mediated programmed mathematics course on review material listed above
4. Lecture
5. Discussion
6. Demonstration
7. Study assignments
8. Written exercises
9. Student practice in measuring

Training Aids

1. Mediated programmed instruction
2. Hardcover programmed instruction
3. Chalk board
4. Metric, apothecary, and household equivalency tables
5. Measuring equipment
6. Instructor's guide
7. Student syllabus
8. References

Examination Modes

1. Classroom response
2. Paper and pencil test
3. Rating of performance in simulated practice
4. Rating of performance in work situation (feedback)
5. Oral quiz on knowledge related to performance in simulated practice and work situation (feedback)

3

Training Time

- 1:00 hour didactic
- 2:00 hours supervised practice

LEARNING MODULE IH7
MEDICATIONS: ADMINISTRATION OF ORAL

Tasks

- _____ Check medication board for due medications and treatments
- 320328 Cross check medication and treatment card with KARDEX and doctor's orders
- 150096 Determine when to give prn medication, e.g., pain, sedative, laxative
- 150097 Determine when to give prn cardiovascular medication, e.g., nitroglycerine
- 110063 Verify identification of patient, e.g., treatment, medication, examination
- 150078 Ask patient/check chart for contraindication for treatment, procedure, or test
- 120010 Explain/answer patient's questions regarding examination/test/treatment/procedure
- 130436 Evaluate patient's complaints or symptoms of pain
- 150100 Review blood sugar/fractional urine test prior to administration of insulin
- 240097 Determine expiration date of locally prepared or compounded drugs
- 240168 Check drugs for visible contamination/deterioration, e.g., cloudiness, color change
- 240173 Pour/draw up medications other than narcotics and controlled drugs
- 240177 Dilute, mix powdered medications
- 140085 Give oral medications
- 140012 Give sublingual/buccal medications
- 140131 Administer controlled drugs
- 140389 Administer narcotics
- 140470 Administer medication to combative/uncooperative patient
- 240016 Dispose of medications prepared but not administered
- 330407 Chart medication into the patient record
- 150064 Write nursing notes
- _____ Record on nursing care plan
- 330542 Account for keys

Performance Objective (Stimulus)

When assigned by the senior corpsman/technician, nurse, or doctor to give oral medications.

Performance Objective (Behavior)

The corpsman/technician will check for due orders or the need for prn orders; verify the orders and the patient's identity; interpret the medication orders; ascertain that the administration of the medication is not contraindicated and that the drug is not deteriorated or outdated; prepare and administer the medication; observe the patient's response to the drug; record on the patient's record and nursing care plan; clean and tidy drug dispensing area and equipment and maintain drug security.

Performance Objective (Conditions)

With supervision and with or without assistance, depending on the patient's condition.

Performance Objective (Criteria)

In accordance with established standard procedures, techniques, and routines and without error in drug, dosage, and patient identity.

Performance Objective (Consequence)

This action will result in the patient receiving the prescribed medication and an accurate recording of it.

Performance Objective (Next Action)

The next action is to observe the patient for drug effect, side effect, and untoward effects.

Knowledge and Skills

1. Anatomy and physiology of gastrointestinal tract relative to ingestion and absorption of drugs.
2. Types of oral/sublingual pharmaceutical preparations: aqueous solutions, tinctures, syrups, tablets, etc.

3. Common drugs used orally--dosage, effect, side effects, untoward effects, and contraindications
4. Observation techniques for assessing patient's condition and response to medication
5. Communication techniques for giving information to and eliciting it from the patients and staff
6. Use of medication board
7. Routine for verification of medication order and patient's identity
8. Interpretation of medication orders
9. Criteria for identifying outdated or deteriorated drugs
10. Policies and procedures governing use of narcotics and controlled drugs
11. Drug administration dependent on patient's laboratory reports
12. Procedures, techniques, and routines for preparing and administering oral and sublingual medications and lozenges and for recording of administered drug on patient's record and patient care plan.
13. Care or disposal of medication equipment/supplies
14. Security precautions and routines for drugs

Instructional Strategies

1. Pretest and/or review on anatomy and physiology of gastrointestinal tract as related to oral medications; types of pharmaceutical preparations and drugs commonly administered orally; computation and measurement of drugs; criteria for determining outdated and deteriorated drugs; security procedures and routines for drugs; communication and observation skills; verification of doctor's orders and patient's identity; routines for reporting and recording.
2. Slides, filmstrips, films, videotapes, and/or mediated programmed instruction (individual or group) on procedures, techniques, and routines for administering oral medications.
3. Lecture
4. Discussion
5. Demonstration
6. Practice in simulated patient care unit
7. Study assignments
8. Written exercises

Training Aids

1. Filmstrips/films/videotapes
2. Mediated programmed instruction
3. Chalk board
4. Equipment and supplies
5. Instructor's guide
6. Student syllabus
7. References

Examination Modes

1. Response in classroom
2. Paper and pencil test
3. Rating on performance in simulated practice
4. Rating on performance in work situation (feedback)
5. Oral quiz on knowledge related to performance in simulated practice and work situation (feedback)

Training Time

- 1:30 hours didactic
- 0:30 hour supervised practice

LEARNING MODULE IHS
MEDICATIONS: ADMINISTRATION OF TOPICAL

Tasks

- _____ Check medication board for due medications and treatments
- 320328 Cross check medication and treatment card with KARDEX and doctor's orders
- 150096 Determine when to give prn medications, e.g., pain, sedative, laxative
- 110063 Verify identification of patient, e.g., treatment, medication, examination
- 150078 Ask patient/check chart for contraindication for treatment, procedure, or test
- 120010 Explain/answer patient's questions regarding examination/test/treatment/procedure
- 130436 Evaluate patient's complaints or symptoms, e.g., pain
- 240097 Determine expiration date of locally prepared or compounded drugs
- 240168 Check drugs for visible contamination/deterioration, e.g., cloudiness, color change
- 240173 Pour/draw up medications other than narcotics and controlled drugs
- 240177 Dilute, mix powdered medications
- 140032 Apply topical, skin/lip medication, e.g., ointment, powder
- 140426 Apply topical medication to mucosal tissue, e.g., oral, eye, stoma
- 140223 Apply topical anesthesia
- 140003 Administer eye, ear, nose drops and ointments
- 110025 Give phisoHex/betadine scrub to patient
- 140082 Give medicated bath
- 130487 Perform patch test
- 140086 Administer inoculations and vaccinations
- 140061 Instruct patient/family on post-immunization care and schedule
- 140470 Administer medication to combative/incooperative patient
- 240016 Dispose of medications prepared but not administered
- 330407 Chart medication into the patient record
- 150064 Write nursing notes
- _____ Record on nursing care plan
- 330542 Account for keys

Performance Objective (Stimulus)

When assigned by the senior corpsman/technician, nurse, or doctor to give topical medications.

Performance Objective (Behavior)

The corpsman/technician will check for due orders or the need for prn orders; verify the orders and the patient's identity; ascertain that the medication is not contraindicated and that the drug is not deteriorated or outdated; prepare and administer medications to the derma and mucosa; and record on the patient's record and nursing care plan.

Performance Objective (Conditions)

With supervision and with or without assistance, depending on the patient's condition.

Performance Objective (Criteria)

In accordance with established standard procedures, techniques, and routines and without error in drug, dosage, and patient identity.

Performance Objective (Consequence)

This action will result in the patient receiving the prescribed medication and accurate recording of it.

Performance Objective (Next Action)

The next action is to observe the patient's response to the medication.

Knowledge and Skills

1. Anatomy and physiology of the skin, stoma, and mucosa relative to absorption, injury, etc.
2. Types of topical pharmaceutical preparations: ointments, powder, solutions, etc.
3. Common drugs applied topically--dosage, effect, side effects, untoward effects, and contraindications
4. Observation techniques for assessing patient's condition

5. Communication techniques for giving information to and eliciting it from patient and staff
6. Use of medication board
7. Routine for verification of medication orders and patient's identity
8. Interpretation of medication orders
9. Criteria for identifying outdated or deteriorated drugs
10. Policies and procedures governing use of narcotics and controlled drugs
11. Procedures, techniques, and routines for preparing and administering topical medications to skin, mucosa, and stoma, with and without dressings.
12. Routines and procedures for recording on patient record and patient care plan
13. Care/disposal of medication equipment/supplies
14. Security procedures and routines for drugs

Instructional Strategies

1. Pretest and/or review on anatomy and physiology of skin, mucosa, and stoma; commonly used topical drugs, dosage strength, effect, side effects, untoward effects, and contraindications; computation for preparing solutions; observation and communication techniques; routines for reporting and recording.
2. Slides, filmstrips, films, videotapes, and/or mediated programmed instruction (individual or group) on procedures, techniques, and routines for applying topical medications.
3. Lecture
4. Demonstration
5. Discussion
6. Practice in simulated patient care unit
7. Study assignments
8. Written exercises

Training Aids

1. Filmstrips/films/videotapes
2. Mediated programmed instruction
3. Wall charts
4. Chalk board
5. Anatomical models

6. Equipment and supplies
7. Instructor's guide
8. Student syllabus
9. References

Examination Modes

1. Response in classroom
2. Paper and pencil test
3. Rating on performance in simulated practice
4. Rating on performance in work situation (feedback)
5. Oral quiz on knowledge related to performance in simulated practice and work situation (feedback)

Training Time

- 1:30 hours didactic
- 0:30 hour supervised practice

LEARNING MODULE IH9

MEDICATIONS: ADMINISTRATION BY INSTILLATION AND INSERTION

Tasks

- _____ Check medication board for due medications and treatments
- 320328 Cross check medication and treatment card with KARDEX and doctor's orders
- 150096 Determine when to give prn medications, e.g., pain
- 110063 Verify identification of patient, e.g., treatment, medication, examination
- 150078 Ask patient/check chart for contraindication for treatment, procedure, or test
- 120010 Explain/answer patient's questions regarding examination/test/treatment/procedure
- 130436 Evaluate patient's complaints or symptoms of pain
- 240097 Determine expiration date of locally prepared or compounded drugs
- 240168 Check drugs for visible contamination/deterioration, e.g., cloudiness, color change
- 240173 Pour/draw up medications other than narcotics and controlled drugs
- 240177 Dilute, mix powdered medications
- 140003 Administer eye, ear, nose drops and ointment
- 140010 Insert rectal suppository or medication
- 140191 Insert vaginal suppository
- 140322 Give medicinal/retention enema, e.g., barium, oil
- 140470 Administer medication to combative/uncooperative patient
- 240016 Dispose of medications prepared but not administered
- 330407 Chart medication into the patient record
- 140064 Write nursing notes
- _____ Record on nursing care plan
- 330542 Account for keys

Performance Objective (Stimulus)

When assigned by the senior corpsman/technician, nurse, or doctor to give medications by instillation or insertion.

Performance Objective (Behavior)

The corpsman/technician will check for due orders or the need for prn orders; verify the order and the patient's identity; interpret the medication orders; ascertain that the administration of the medication is not contraindicated and that the drug is not deteriorated or outdated; prepare and administer the medication; observe the patient's response to the drug; record on the patient's record and nursing care plan; clean and tidy drug dispensing area and equipment; and maintain drug security.

Performance Objective (Conditions)

With supervision and with or without assistance, depending on the patient's condition.

Performance Objective (Criteria)

In accordance with the established standard procedures, techniques, and routines for instillation and insertion and without error in the drug, dosage, and patient's identity.

Performance Objective (Consequence)

This action will result in the patient receiving the prescribed medication and an accurate recording of it.

Performance Objective (Next Action)

The next action is to observe the patient's response to the drug therapy.

Knowledge and Skills

1. Anatomy and physiology of body orifices, namely eyes, ears, nose, rectum, and vagina as related to instillation and insertion of drugs.
2. Types of pharmaceutical preparations and common drugs used for instillation and insertion into body orifices, dosage, effect, side effects, untoward effects, and contraindications.
3. Observation techniques for assessing patient's condition and response to the drug therapy.
4. Communication techniques for giving information to and eliciting it from patient and staff members.

5. Use of medication board
6. Routines for verification of medication order and patient's identity
7. Interpretation of medication orders
8. Criteria for identifying deteriorated and outdated drugs
9. Policies and procedures governing use of narcotics and controlled drugs
10. Procedures, techniques, and routines for preparing and administering medications by instillation and insertion.
11. Routine and procedures for recording administered medication on the patient's record and nursing care plan.
12. Care or disposal of medication equipment and supplies
13. Security procedures and routines for drugs

Instructional Strategies

1. Pretest and/or review on anatomy and physiology of body orifices; types of pharmaceutical preparations and common drugs used for instillation and insertion into body orifices; observation and communication techniques; routines for reporting and recording.
2. Slides, filmstrips, films, videotapes, and/or mediated programmed instruction (individual or group) on procedures, techniques, and routines for administering drugs by insertion and various kinds of instillations.
3. Lecture
4. Discussion
5. Demonstration
6. Practice in simulated patient care unit
7. Study assignments
8. Written exercises

Training Aids

1. Filmstrips/films/videotapes
2. Mediated programmed instruction
3. Slides
4. Chalk board
5. Anatomical models
6. Equipment and supplies
7. Instructor's guide

8. Student syllabus

9. References

Examination Modes

1. Response in classroom
2. Paper and pencil test
3. Rating on performance in simulated practice
4. Rating on performance in work situation (feedback)
5. Oral quiz on knowledge related to performance in simulated practice and work situation (feedback)

Training Time

1:00 hour didactic

0:45 hour supervised practice

LEARNING MODULE IH10

MEDICATIONS: ADMINISTRATION OF SUBCUTANEOUS AND INTRAMUSCULAR

Tasks

- _____ Check medication board for due medication and treatments
- 320328 Cross check medication and treatment card with KARDEX and doctor's orders
- 150096 Determine when to give prn medication, e.g., pain, sedative, laxative
- 150097 Determine when to give prn cardiovascular medication, e.g., nitro-glycerine
- 110063 Verify identification of patient, e.g., for treatment, medication, examination
- 150078 Ask patient/check chart for contraindication for treatment, procedure, or test
- 120010 Explain/answer patient's questions regarding examination/test/treatment/procedure
- 130436 Evaluate patient's complaints or symptoms of pain
- 150100 Review blood sugar/fractional urine test prior to administration of insulin
- 150053 Review prothrombin time/clotting time prior to administration of anticoagulant
- 150153 Determine/alter heparin dose according to specified clotting time
- 240097 Determine expiration date of locally prepared or compounded drugs
- 240168 Check drugs for visible contamination/deterioration, e.g., cloudiness, color change
- 240173 Pour/draw up medications other than narcotics and controlled drugs
- 240177 Dilute, mix powdered medications
- 140011 Administer subcutaneous injection
- 140470 Administer medication to combative/uncooperative patient
- 140005 Administer intramuscular injection
- 140389 Administer narcotics
- 140131 Administer controlled drugs
- 240122 Prepare local anesthesia solutions for use
- 240016 Dispose of medications prepared but not administered
- 330407 Chart medication into the patient record
- 150064 Write nursing notes

_____ Record on nursing care plan
330542 Account for keys

Performance Objective (Stimulus)

When assigned by the senior corpsman/technician, nurse, or doctor to give subcutaneous and intramuscular medications.

Performance Objective (Behavior)

The corpsman/technician will check for due orders or the need for prn orders, verify the orders and the patient's identity; interpret the medication orders; ascertain that the administration of the medication is not contraindicated and that the drug is not outdated or deteriorated; prepare and administer the medication; observe the patient's response to the drug; record on the patient's record and nursing care plan; clean and tidy drug dispensing area and equipment and maintain drug security.

Performance Objective (Conditions)

With supervision and with or without assistance, depending on the patient's condition.

Performance Objective (Criteria)

In accordance with established standard procedures, techniques, and routines and without error in drug, dosage, and patient identity.

Performance Objective (Consequence)

This action will result in the patient receiving the prescribed medication and an accurate recording of it.

Performance Objective (Next Action)

The next action is to observe the patient's response to the administered drug.

Knowledge and Skills

1. Anatomy and physiology of subcutaneous and muscle tissue
2. Anatomical sites for administration of subcutaneous and intramuscular medications
3. Types of pharmaceutical preparations and drugs commonly administered subcutaneously and intramuscularly; dosage, effect, side effect, untoward effect and contraindication.
4. Observation techniques for assessing patient's condition and response to drug
5. Communication techniques for giving information to and eliciting it from patients and staff members.
6. Sterile technique for giving subcutaneous and intramuscular medications
7. Use of medication board
8. Routines for verification of medication orders and patient's identity
9. Interpretation of medication orders
10. Criteria for identifying outdated and deteriorated drugs
11. Policies and procedures governing use of narcotics and controlled drugs
12. Drug administration dependent on patient's laboratory reports
13. Procedures, techniques, and routines for preparing and administering subcutaneous and intramuscular medications prescribed in metric and unit dosages.
14. Routines and procedures for recording administered medications on patient's record and patient care plan.
15. Care or disposal of medication equipment and supplies
16. Security procedures and routines for drugs

Instructional Strategies

1. Pretest and/or review on anatomy and physiology of subcutaneous and muscle tissues; types of pharmaceutical preparations and drugs commonly administered by subcutaneous and intramuscular routes; computation and measurement of fractional dosage; observation and communication techniques; routines for reporting and recording.
2. Slides, filmstrips, films, videotapes, and/or mediated programmed instruction (individual or group) on procedures, techniques, and routines for administering drugs by subcutaneous and intramuscular routes.
3. Lecture
4. Discussion
5. Demonstration

6. Practice in simulated patient care unit
7. Study assignments
8. Written exercises

Training Aids

1. Filmstrips/films/videotapes
2. Mediated programmed instruction
3. Slides
4. Chalk board
5. Anatomical models
6. Equipment and supplies
7. Student syllabus
8. References

Examination Modes

1. Response in classroom
2. Paper and pencil test
3. Rating on performance in simulated practice
4. Rating on performance in work situation (feedback)
5. Oral quiz on knowledge related to performance in simulated practice and work situation (feedback)

Training Time

- 1:30 hours didactic
- 1:00 hour supervised practice

LEARNING MODULE IH11
MEDICATIONS: ADMINISTRATION OF INTRAVENOUS

Tasks

- _____ Check medication board for due medications and treatments
- 320328 Cross check medication and treatment card with KARDEX and doctor's orders
- 150096 Determine when to give prn medications, e.g., pain, sedative, laxative
- 150097 Determine when to give prn cardiovascular medications, e.g., nitroglycerine
- 110063 Verify identification of patient, e.g., treatment, medication, examination
- 150078 Ask patient/check chart for contraindication for treatment, procedure, or test
- 120010 Explain/answer patient's questions regarding examination/test/treatment/procedure
- 130436 Evaluate patient's complaints or symptoms of pain
- 240097 Determine expiration date of locally prepared or compounded drugs
- 240168 Check drugs for visible contamination/deterioration, e.g., cloudiness, color change
- 240173 Pour/draw up medications other than narcotics and controlled drugs
- 240177 Dilute, mix powdered medications
- 130487 Perform patch test
- _____ Assist with/administer intravenous medications
- 240186 Add medications to and label intravenous solutions
- 240174 Administer medications directly into I.V. tubing
- 140281 Administer I.V. medications via soluset, "piggy back," I.V. bottles
- 140131 Administer controlled drugs
- 140389 Administer narcotics
- 140476 Administer I.V. medications to combative/uncooperative patient
- 130493 Check intravenous site for infiltration, phlebitis, cellulitis
- 240016 Dispose of medications prepared but not administered
- 330407 Chart medication into the patient record
- 150064 Write nursing notes
- _____ Record on nursing care plan
- 330542 Account for keys

Performance Objective (Stimulus)

When assigned by the senior corpsman/technician, nurse, or doctor to administer medications by intravenous route.

Performance Objective (Behavior)

The corpsman/technician will check the due orders or need for prn orders; verify the orders and the patient's identity; interpret the medication orders; ascertain that the administration of the medication is not contraindicated and that the drug is not outdated or deteriorated; prepare and administer or assist with the administration of the medication by intravenous route; observe the patient's reaction to the drug; record on the patient's record and nursing care plan; clean and tidy drug dispensing area and equipment; and maintain drug security.

Performance Objective (Conditions)

With supervision and without assistance unless the drug is of the type to require that a physician administer it or the patient's condition requires an assistant.

Performance Objective (Criteria)

In accordance with established standard procedures, techniques, and routines and without error in drug dosage, patient identity, and sterile techniques.

Performance Objective (Consequence)

This action will result in the patient receiving the prescribed medication and an accurate recording of it.

Performance Objective (Next Action)

The next action is to monitor the patient for his response to the drug.

Knowledge and Skills

1. Location of the veins into which drugs are most frequently administered and structure of surrounding tissue.

2. Types of pharmaceutical preparations and the drugs used for intravenous administration frequently; their dosage, effect, side effects, untoward effects and contraindications for use.
3. Observation techniques for assessing patient's condition and response to intravenous drug therapy.
4. Communication techniques for giving information to and eliciting it from patients and staff members.
5. Sterile techniques for giving intravenous drugs
6. Use of medication board
7. Routines for verification of medication orders and patient's identity
8. Interpretation of medication orders
9. Criteria for identifying outdated and deteriorated drugs
10. Policies and procedures governing use of narcotics and controlled drugs
11. Drug administration dependent on patient's laboratory reports
12. Procedures, techniques, and routines for preparing and administering intravenous drugs or assisting with their administration.
13. Routines and procedures for recording administered medications on patient's record and nursing care plan.
14. Care and disposal of medication equipment and supplies
15. Security precautions and routine for drugs

Instructional Strategies

1. Pretest and/or review on anatomical structure and location of veins and structure of surrounding tissues; types of pharmaceutical preparations and drugs commonly administered intravenously; computation and measurement of dosage; sterile technique for administering intravenous drugs; procedure and techniques for vena puncture; observation and communication techniques; routines for reporting and recording.
2. Slides, filmstrips, films, videotapes, and/or mediated programmed instruction (individual or group) on procedures, techniques, and routines for administering drugs by intravenous route.
3. Lecture
4. Discussion
5. Demonstration
6. Practice in simulated patient care unit
7. Study assignments
8. Written exercises

Training Aids

1. Filmstrips/films/videotapes
2. Mediated programmed instruction
3. Chalk board
4. Anatomical models
5. Equipment and supplies
6. Instructor's guide
7. Student syllabus
8. References

Examination Modes

1. Response in classroom
2. Paper and pencil test
3. Rating on performance in simulated practice
4. Rating on performance in work situation (feedback)
5. Oral quiz on knowledge related to performance in simulated practice and work situation (feedback)

Training Time

- 1:00 hour didactic
- 0:30 hour supervised practice

LEARNING MODULE IH12

MEDICATIONS: ADMINISTRATION OF INOCULATIONS, VACCINATIONS, AND SKIN TESTS

Tasks

- 150137 Ensure that doctor's orders are carried out
- 150158 Determine immunization required for overseas travel
- 150159 Determine sequence of administration of multiple immunizations
- 240076 Prepare vaccine for use
- 240174 Label multiple vials with date, time, concentration, and initials
- 110063 Verify identification of the patient, e.g., treatment, medication, examination
- 150078 Ask patient/check chart for contraindications for treatment, procedure or test
- 120010 Explain/answer patient's questions regarding examination/test/treatment/procedure
- 240127 Answer inquiries regarding drug reaction
- 240168 Check drugs for visible contamination/deterioration, e.g., cloudiness, color change
- 240097 Determine expiration date of locally prepared or compounded drugs
- _____ Wash hands prior to/after patient care, medication, treatment, examination, procedure, specimen collecting and handling
- 240173 Pour/draw up medications other than narcotics and controlled drugs
- 140080 Administer inoculations and vaccinations
- 120061 Instruct patient/family on immunization care and schedule
- 140004 Give intradermal injections
- 130279 Give histoplasmosis/coccidioidomycosis skin test
- 130462 Give tuberculin PPD test
- 130075 Give tuberculin Mantoux test
- 130076 Give tuberculin Tine test
- 130131 Read tuberculin test reaction
- 330407 Chart medication into the patient's record

Performance Objective (Stimulus)

When assigned by the senior corpsman/technician, nurse, or doctor to administer inoculations, vaccinations, and skin test as ordered by the physician.

Performance Objective (Behavior)

The corpsman/technician will verify the doctor's order and patient's identity; determine the immunization required for overseas travel and the sequence of multiple immunizations; explain the procedure and the reaction of the drug to the patient and determine any contraindications to the immunizations or tests; wash hands; prepare and administer the immunization; instruct the patient and/or family on post-immunization care and schedule for return; and if indicated read the results.

Performance Objective (Conditions)

With indirect supervision and without assistance, except in the case of combative patient, with an assistant.

Performance Objective (Criteria)

In accordance with established standard routines, procedures, and techniques.

Performance Objective (Consequence)

The patient receives his immunization or test and follow-up reading according to standard procedure and schedule.

Performance Objective (Next Action)

The next action is to clean up and care for equipment.

Knowledge and Skills

1. Sites for administering various immunizations and tests
2. Immunization requirements for various parts of the world
3. Communication techniques for giving information to and eliciting it from patients and/or family relative to immunization and tests.
4. Instructional techniques for teaching patient and/or family relative to immunization or test procedure and schedule.
5. Method for reading results of certain immunizations and tests
6. Criteria for identifying outdated and deteriorated immunization and test drugs
7. Purpose of hand washing

8. Procedures, techniques, and routines for preparing and administering various types of immunizations and tests.
9. Schedules for various types of immunizations
10. Procedure, techniques, and routines for recording immunizations and tests on required records
11. Care or disposal of used equipment and supplies

Instructional Strategies

1. Pretest and/or review on anatomy and physiology of dermal tissue; types of drugs given for vaccinations, inoculations, and skin tests and their effects, side effects, and untoward effects; computation and measurement of dosage; observation, communication, and instructional techniques; and routines for reporting and recording.
2. Slides, filmstrips, films, videotapes, and/or mediated programmed instruction (individual or group) on procedures, techniques, and routines for preparing, administering, and recording immunizations, inoculations, and skin tests and their results; reading immunization results and giving instructions to the patient and/or family.
3. Hardcover programmed instruction
4. Lecture
5. Discussion
6. Demonstration
7. Practice in simulated patient care unit
8. Study assignments
9. Written exercises

Training Aids

1. Filmstrips/films/videotapes
2. Mediated programmed instruction
3. Hardcover programmed instruction
4. Slides
5. Wall charts--depicting world areas and their immunization requirements
6. Chalk board
7. Equipment and supplies
8. Instructor's guide
9. Student syllabus
10. References

Examination Modes

1. Response in classroom
2. Paper and pencil test
3. Rating on performance in simulated practice
4. Rating on performance in work situation (feedback)
5. Oral quiz on knowledge related to performance in simulated practice and work situation (feedback)

Training Time

0:30 hour didactic

0:45 hour supervised practice

LEARNING MODULE IH13

MEDICATIONS: INSTRUCTION TO PATIENT FOR SELF-ADMINISTRATION

Tasks

- 120101 Teach patient self-administration of medication other than injections
- 120129 Teach patient/family administration of injections
- 120052 Explain/answer patient's/family's questions about medication, e.g., purpose, dose, schedule
- 120050 Inform patient/family of reaction from medication, e.g., urine discoloration, drowsiness, excitability
- 240093 Answer patient/family inquiries regarding mixing/administering drugs
- 120118 Inform patient/family of symptoms of intolerance/overdose to medication, e.g., bleeding gums, coma, etc.
- 240127 Answer inquiries regarding drug reaction
- 120063 Inform family where to obtain medical supplies
- 120082 Answer patient/family regarding nonprescription drugs
- 120119 Review printed instructions on examination/therapy with patient/family

Performance Objective (Stimulus)

When necessary for a patient to administer his own medication.

Performance Objective (Behavior)

The corpsman/technician will teach the patient and/or his family on the correct procedure for obtaining the medication, storing the drug, interpreting the label instructions, preparing, taking, or giving the drug, effect of the drug, side effects of drug and symptoms of untoward effects.

Performance Objective (Conditions)

With selective supervision and without assistance.

Performance Objective (Criteria)

The patient and/or his family understand the instructions.

Performance Objective (Consequence)

This action will result in the patient or his family being able to procure and store properly his medication, administer it correctly, and recognize its effects, side effects, and untoward effects.

Performance Objective (Next Action)

The next action is to record the instructions given to the patient.

Knowledge and Skills

1. Content of instructions to be given
2. Procedure, techniques, and routines for giving complete, concise, and clear instructions
3. Checking of patient's ability to give medication and knowledge of the significance of proper storage and of symptoms of effects, side effects, and untoward effects.
4. Checking on patient's understanding of verbal instructions and of written instructions when provided.

Instructional Strategies

1. Pretest and/or review on instructional skills
2. Slides, filmstrips, films, videotapes, and/or mediated programmed instruction (individual or group) on teaching the patient or his family self-administration of a medication.
3. Lecture
4. Discussion
5. Demonstration
6. Role playing
7. Study assignments

Training Aids

1. Filmstrips/films/videotapes
2. Mediated programmed instruction
3. Chalk board
4. Equipment and supplies--written instructions for the patient
5. Instructor's guide

6. Student syllabus
7. References

Examination Modes

1. Response in classroom
2. Paper and pencil test
3. Rating on performance in simulated practice
4. Rating on performance in work situation (feedback)
5. Oral quiz on knowledge related to performance in simulated practice and work situation (feedback)

Training Time

- 0:45 hour didactic
- 0:30 hour supervised practice

TRAINING UNIT I-I
PATIENT HYDRATION AND BLOOD TRANSFUSIONS

Learning Modules

- I-I1. Fluid Balance: Intake and Output
- I-I2. Fluid Balance: Administration of Subcutaneous Fluids (Hypodermoclysis)
- I-I3. Fluid Balance: Administration of Intravenous Fluids
- I-I4. Blood Transfusion: Administration of

Training Objective

Upon completion of this training unit, the learner will be able to verify the doctor's orders and patient's identity; inform the patient about the procedure, answer his questions, and reassure him; determine any contraindications to the procedure; observe and report the signs and symptoms of dehydration or fluid retention; set up and monitor the patient's force or limit fluid routine; measure and record the patient's intake and output and determine fluid imbalance; set up and assist with the starting and monitoring of the flow and the patient's reaction to hypodermoclysis, intravenous infusions, and transfusions; draw blood for typing and cross matching; take emergency measures for transfusion reaction; report to supervisor the patient's condition and response to procedures and record on nursing notes, nursing care plan, and other required records.

The learner must be able to accomplish the foregoing with supervision and, in some instances, with selective supervision. He will perform with or without assistance, depending upon the condition of the patient. He will require infrequent technical assistance. He must be able to perform according to established standard procedures, techniques, and routines, without error in intravenous fluids and drugs and type of blood.

These actions will result in the patient being maintained in a state of hydration with input as prescribed by the physician. The patient will also be provided with required blood transfusions as prescribed by the doctor.

Knowledge and Skills

1. Purpose of subcutaneous (hypodermoclysis) fluids, intravenous fluids
2. Significance of body fluids, fluid balance, force fluids, limit fluids, input and output measurement, and recording.
3. Anatomy and physiology of blood vessels and subcutaneous tissue
4. Blood types and their significance
5. Observation techniques as related to signs and symptoms of fluid retention and dehydration.
6. Communication techniques for giving information to and eliciting it from the patient and reporting to supervisory personnel.
7. Sites for administration of subcutaneous and intravenous fluids
8. Sterile technique as related to subcutaneous and intravenous fluid administration
9. Drugs commonly administered with intravenous fluids; dosage, effects, side effects, and untoward effects.
10. Routine for verification of doctor's orders and patient's identity
11. Patient's disease, therapy, and condition as related to fluid forcing and restriction, subcutaneous fluids, intravenous fluids, and blood transfusions.
12. Procedures, techniques, and routines for measuring and recording intake and output and determining significant imbalance. Also, assessment of non-measurable output and recording on nursing notes.
13. Procedures, techniques, and routines for forcing and restricting fluids and administering subcutaneous and intravenous fluids, including kinds of fluids, contraindications, and precautionary measures; and recording on nursing notes and nursing care plan.
14. Procedures, techniques, and routines for drawing blood for typing and cross matching; obtaining blood; setting up and assisting the doctor in starting transfusion; monitoring flow and observing for any symptoms of reaction; taking emergency steps for reaction and reporting.
15. Procedures, techniques, and routines for administering drugs with intravenous fluids, contraindications, and precautionary measures. Also, recording on nursing notes and nursing care plan.
16. Routine for equipment care following use

Instructional Strategies

1. Pretest and/or review on observation, communication, and instructional skills; anatomy and physiology of blood vessels and subcutaneous tissue; intravenous medications; verification of doctor's orders and patient's

identity; sterile technique related to vena puncture and subcutaneous injections; fluids as related to nutrition and diets; recording on patient record and patient care plan.

2. Slides, filmstrips, films, videotapes, and/or mediated programmed instruction (individual or group) on signs and symptoms of dehydration and fluid retention; procedures and techniques for encouraging and restricting fluid intake; measuring and recording fluid intake and output, and computing 24-hour total fluid intake and output; procedures, techniques, and routines for preparing and administering intravenous fluids with or without medications; subcutaneous fluids by hypodermoclysis; and blood transfusions.
3. Hardcover programmed instruction for presenting knowledges and skills not requiring motion
4. Lecture
5. Discussion
6. Demonstration
7. Practice in simulated patient care unit
8. Study assignments
9. Written exercises
10. Case studies
11. Problem solving situations

Training Aids

1. Filmstrips/films/videotapes
2. Mediated programmed instruction
3. Hardcover programmed instruction
4. Slides
5. Wall charts
6. Chalk board
7. Anatomical models
8. Equipment and supplies
9. Instructor's guide
10. Student syllabus
11. References

Examination Modes

1. Response in classroom
2. Paper and pencil test
3. Rating on performance in simulated practice
4. Rating on performance in work situation (feedback)
5. Oral quiz on knowledge related to performance in simulated practice and work situation (feedback)

Training Time

3:00 hours didactic

2:30 hours supervised practice

LEARNING MODULE I-11
FLUID BALANCE: INTAKE AND OUTPUT

Tasks

- 320328 Cross check medication and treatment cards with KARDEX and doctor's orders
- 110063 Verify identification of patient, e.g., for treatment, medication, examination
- _____ Wash hands prior to and after patient care, medication, treatment, examination, procedure, specimen collecting and handling
- 120080 Inform patient of procedure prior to/during examination/test/treatment
- 150078 Ask patient/check chart for contraindications for treatment/procedure/tests
- 120010 Explain/answer patient's questions regarding examination/test/treatment/procedure
- 330143 Place special treatment tags over/on bed, e.g., fasting, force fluids
- 130260 Observe and report symptoms of dehydration
- 130408 Check texture of skin, e.g., dry, oily, scaly
- 130239 Check skin turgor (elasticity)
- 130410 Check patient for sweating/diaphoresis
- 130240 Check patient for edema (swelling) of extremities, eyes
- 130254 Palpate (feel) abdomen for distention (fullness)
- 130404 Check/count respirations
- 130075 Estimate and record blood loss during hemorrhage
- 130027 Observe for/report symptoms of diarrhea
- 130580 Observe for/report decreased output of patient susceptible to renal shutdown
- 140279 Force fluid intake
- 150112 Calculate plan for oral fluid restrictions
- 130005 Record/tally fluid intake and output
- 130498 Measure contents of drainage container, e.g., bags, bottles, basins, urinals
- _____ Record intake and output sheet
- 130400 Report changes or imbalances in intake and output
- 150064 Write nursing notes
- _____ Record on nursing care plan

- 150013 Make suggestions regarding patient care
- 150082 Suggest changes in nursing care plan for patient
- 150102 Initiate and implement changes in patient's nursing care plan
- 150085 Modify patient care plan according to patient's response and needs,
e.g., physical activity
- 250039 Plot readings/values on rectilinear graph paper

Performance Objective (Stimulus)

When assigned by the senior corpsman/technician, nurse, or doctor to force or limit fluids as ordered by the physician, and to observe for signs and symptoms of dehydration or fluid retention.

Performance Objective (Behavior)

The corpsman/technician will verify the doctor's orders and patient's identity; wash hands; set up and monitor the patient's force or limit fluid routine; measure and record or have patient measure and record time, amount, and kind of fluid intake and the output; observe and record fluid loss that is not measurable; observe for signs and symptoms of dehydration or fluid retention; report fluid hydration status to supervisory personnel; make suggestions for changes in fluid intake and modify nursing care plan accordingly; total input and output for 24-hour periods and record on input and output record, TPR graphic sheet, and nursing notes.

Performance Objective (Conditions)

With selective supervision and with assistant who assists the patient in meeting fluid intake requirements.

Performance Objective (Criteria)

In accordance with doctor's orders and established standard procedures, techniques, and routines.

Performance Objective (Consequence)

The patient's fluids being in balance and his receiving fluid intake as prescribed by the physician.

Performance Objective (Next Action)

The next action is the continuous monitoring of patient's intake and output and his fluid balance.

Knowledge and Skills

1. Significance of fluid balance to body functions and disease conditions
2. Significance of accurate recording of measurable fluid intake: oral, intravenous, hypodermoclysis, and rectal.
3. Significance of accurate recording of measurable output: urine, vomitus, watery stools, drainage, and aspiration from body cavities. Also, significance of recording of non-measurable output, such as hemorrhage, diaphoresis, and respiratory exhalation.
4. Kinds of fluids as related to patient's condition, such as diabetic
5. Communication techniques for giving information to or eliciting it from the patient and reporting procedure and patient's condition.
6. Observation of signs and symptoms of dehydration, such as lack of skin turgor, dry mouth, coated tongue, and of fluid retention, such as edema, distention.
7. Instructional techniques for teaching the patient to force or restrict fluids and to measure and record them.
8. Routine for verifying doctor's orders and patient's identity
9. Purpose of hand washing
10. Patient's disease, therapy, and condition as related to fluid balance and kinds of fluids.
11. Procedures, techniques, and routines for forcing or limiting fluids, measuring and recording input and output, and computing and recording 24-hour totals and teaching the patient the procedure, techniques, and routines for measuring and recording intake and output.

Instructional Strategies

1. Pretest and/or review on: communication, observation, and instructional techniques; fluids as related to diet and nutrition and significance of fluid balance to body functions; measurement.
2. Slides, filmstrips, films, videotapes, and/or mediated programmed instruction (individual or group) on signs and symptoms of dehydration and fluid retention; kinds of fluids as related to patient's condition; procedures, techniques, and routines for encouraging (forcing) and restricting (limiting) fluids; recording intake and output and computing 24-hour total intake, output, and fluid imbalance.

3. Hardcover programmed instruction
4. Lecture
5. Discussion
6. Demonstration
7. Study assignments
8. Written exercises
9. Case studies
10. Problem solving situations

Training Aids

1. Filmstrips/films/videotapes
2. Mediated programmed instruction
3. Hardcover programmed instruction
4. Slides
5. Chalk board
6. Instructor's guide
7. Student syllabus
8. References

Examination Modes

1. Response in classroom
2. Paper and pencil test
3. Rating on performance in simulated practice
4. Rating on performance in work situation (feedback)
5. Oral quiz on knowledge related to performance in simulated practice and work situation (feedback)

Training Time

0:30 hour didactic

LEARNING MODULE I-12

FLUID BALANCE: ADMINISTRATION OF SUBCUTANEOUS FLUIDS (HYPODERMOCLYSIS)

Tasks

- 320328 Cross check medication and treatment card with KARDEX and doctor's orders
- 110063 Verify identification of patient, e.g., for treatment, medication, examination
- 120080 Inform patient of procedure required prior to/during examination/test/treatment
- 120012 Explain physiological basis for therapy/treatment to patient/family
- 120010 Explain/answer patient's questions regarding examination/test/treatment/procedure
- 150141 Elicit information to ascertain patient's understanding of illness/treatment
- 120046 Reassure/calm apprehensive/anxious patient
- 150078 Ask patient/check chart for any contraindications of procedure or test
- 145041 Arrange furniture/set up equipment/supplies for procedure, e.g., examination/treatment
- 145019 Obtain equipment, medications, instruments prn for personnel performing sterile procedure
- 240168 Check drugs for visible contamination/deterioration, e.g., cloudiness, color change
- 110043 Prepare skin site with antiseptic solution prior to incision/suturing/treatment/examination
- _____ Give hypodermoclysis
- 150143 Initiate treatment procedure in absence of doctor
- 130097 Observe/report symptoms of side effects of treatment/medication
- 130436 Evaluate patient's complaints or symptoms of pain
- 130382 Observe and record patient's physical/emotional response to treatment/diagnostic procedure
- 150069 Give/receive verbal reports concerning patient
- 150064 Write nursing notes
- _____ Record on intake and output sheet
- _____ Record on TPR graphic chart
- _____ Record on nursing care plan

Performance Objective (Stimulus)

When assigned by the senior corpsman/technician, nurse, or doctor to give a hypodermoclysis ordered by the doctor.

Performance Objective (Behavior)

The corpsman/technician will verify the doctor's orders and the patient's identity; communicate with the patient about the procedure and reassure him; wash hands; set up for the procedure; prepare the patient and start the hypodermoclysis; regulate the flow and monitor the treatment; report the progress of the hypodermoclysis and the patient's condition to supervisory personnel; record the treatment on the patient's record and the nursing care plan; and clean up during and after the procedure.

Performance Objective (Conditions)

With supervision and without assistance, except in the case of combative or helpless patient, when an assistant is required.

Performance Objective (Criteria)

In accordance with established standard procedures, techniques, and routines.

Performance Objective (Consequence)

The patient receives the hypodermoclysis ordered by the physician.

Performance Objective (Next Action)

The next action is terminal cleaning and tidying of patient's unit and making the patient as comfortable as possible.

Knowledge and Skills

1. Purpose of hypodermoclysis
2. Anatomy and physiology of subcutaneous tissue
3. Sites for administration
4. Sterile technique as related to hypodermoclysis procedure
5. Communication techniques for communicating with patient about procedure and reporting to staff.

6. Observation techniques for assessing patient's condition and monitoring hypodermoclysis
7. Routine for verifying doctor's orders and patient's identity
8. Patient's disease, therapy, and condition as related to treatment
9. Preparation of patient and his unit
10. Preparation for hypodermoclysis--equipment and supplies
11. Procedure and techniques for starting hypodermoclysis
12. Care of the patient during and after the treatment
13. Routines and procedures for recording on patient's record and patient care plan
14. Clean up during and after the treatment

Instructional Strategies

1. Pretest and/or review on anatomy and physiology of subcutaneous tissue; communication and observation techniques; reporting and recording procedures, techniques, and routines; sterile technique.
2. Slides, filmstrips, films, videotapes, and/or mediated programmed instruction (individual or group) on procedure, technique, and routines for setting up, starting, monitoring, and discontinuing hypodermoclysis; sites for administration; fluids used.
3. Hardcover programmed instruction
4. Lecture
5. Discussion
6. Demonstration
7. Practice in simulated patient care unit
8. Study assignments
9. Written exercises

Training Aids

1. Filmstrips/films/videotapes
2. Mediated programmed instruction
3. Hardcover programmed instruction
4. Slides
5. Chalk board
6. Anatomical models

7. Equipment and supplies
8. Instructor's guide
9. Student syllabus
10. References

Examination Modes

1. Response in classroom
2. Paper and pencil test
3. Rating on performance in simulated practice
4. Rating on performance in work situation (feedback)
5. Oral quiz on knowledge related to performance in simulated practice and work situation (feedback)

Training Time

- 0:30 hour didactic
- 0:45 hour supervised practice

LEARNING MODULE I-13
FLUID BALANCE: ADMINISTRATION OF INTRAVENOUS FLUIDS

Tasks

- 320328 Cross check medication and treatment card with KARDEX and doctor's orders
- 110063 Verify identification of patient, e.g., for treatment, medication, examination
- 120080 Inform patient of procedure required prior to/during examination test/treatment
- 120012 Explain physiological basis for therapy/treatment to patient/family
- 120010 Explain/answer patient's questions regarding examination/test/treatment/procedure
- 150141 Elicit information to ascertain patient's understanding of illness/treatment
- 120046 Reassure/calm apprehensive/anxious patient
- 150078 Ask patient/check chart for any contraindications of procedure or test
- 330207 Inform doctor of any contraindications to study
- Wash hands prior to/after patient care, medication, treatment, examination, procedure, and specimen collecting and handling
- 145041 Arrange furniture/set up equipment/supplies for procedure, e.g., examination/treatment
- 240168 Check drugs for visible contamination/deterioration, e.g., cloudiness, color change
- 110081 Position/hold patient for examination, treatment, surgery
- 110043 Prepare skin site with antiseptic solution prior to incision/suturing/treatment/examination
- 150143 Initiate treatment procedure in absence of doctor
- 140477 Initiate I.V. therapy
- 140167 Start I.V. therapy via medicut (angiocath, jelco)
- 140170 Start I.V. therapy via needle
- 140146 Regulate I.V. flow within standard limits
- 140374 Calculate rate of I.V. flow, e.g., drops per minute
- 140284 Add/change I.V. bottle during continuous infusion
- 140282 Irrigate I.V. tubing
- 140388 Administer medication directly into I.V. tubing

- 140288 Administer I.V. medication via soluset, piggy back, or I.V. bottle
- 240186 Add medication to and label intravenous solutions
- 140192 Administer blood expander other than blood, e.g., plasma, albumin
- 130097 Observe/report symptoms of side effects of treatment/medication
- 130436 Evaluate patient's complaints or symptoms of pain
- 130382 Observe and record patient's physical/emotional response to treatment/
diagnostic procedure
- 130493 Check intravenous site for infiltration, phlebitis, cellulitis
- 150047 Carry out doctor's verbal orders
- 150069 Give/receive verbal reports concerning patient
- 140065 Discontinue I.V. therapy
- 150064 Write nursing notes
- _____ Record on intake and output sheet
- _____ Record on TPR graphic chart
- _____ Record on nursing care plan

Performance Objective (Stimulus)

When assigned by the senior corpsman/technician, nurse, or doctor to assist with or administer intravenous fluids and medications ordered by the physician.

Performance Objective (Behavior)

The corpsman/technician will check the orders; verify the patient's identity; ascertain that intravenous fluids are not contraindicated; ascertain that the patient understands the therapy and procedure; wash hands; set up for the procedure; inspect solution for deterioration; assist with or start the intravenous fluids; regulate the flow; add drugs to the intravenous; change I.V. bottles; irrigate I.V. tubing; monitor the flow and the patient's reaction and give verbal reports on progress and results; discontinue the intravenous; and record on the nursing notes, nursing care plan, intake and output record, and TPR graphic chart.

Performance Objective (Conditions)

With supervision and technical assistance if indicated by the patient's condition. If assisting the doctor with the procedure, he will follow the physician's verbal instructions.

Performance Objective (Criteria)

In accordance with established standard procedures and routines, without error in patient identification, intravenous fluids and drugs; fluid amount and drug dosage, rate of flow, maintenance of sterile technique and accurate recording of the procedure.

Performance Objective (Consequence)

The patient receives the prescribed intravenous fluids and medications and an accurate recording is made of the fluids and medication and the patient's response to the procedure.

Performance Objective (Next Action)

The next action is to clean up after the procedure and to make the patient comfortable.

Knowledge and Skills

1. Purpose of intravenous fluids
2. Anatomy and physiology of blood vessels
3. Anatomical sites for giving intravenous fluids
4. Sterile techniques for giving intravenous fluids
5. Types of solutions given intravenously
6. Common drugs administered with intravenous fluids; their effects, side effects, and untoward effects.
7. Communicating with the patient to help him understand procedure and treatment and to allay apprehension.
8. Routines for verifying doctor's orders and patient's identity
9. Patient's disease, therapy, and condition as related to intravenous fluids, drugs, and procedures.
10. Contraindications for intravenous therapy
11. Purpose of hand washing
12. Procedures and techniques for preparing the patient, the equipment and supplies, checking the solution and starting the intravenous; regulating the flow, with and without an IVAC pump; replacing emptied I.V. bottles; irrigating I.V. tubing, adding drugs; monitoring the progress and patient's condition; discontinuing the intravenous and recording in nursing notes and on input and output record.

13. Communication with doctor, nurse, or senior corpsman/technician on intravenous progress and patient's condition.
14. Routine for equipment care following use

Instructional Strategies

1. Pretest and/or review on anatomy and physiology of blood vessels and surrounding tissues; fluid balance; intravenous medications--effect, side effects, untoward effects, and contraindications; observation and communication techniques; routine for verifying doctor's orders and patient's identity; routines for reporting and recording.
2. Slides, filmstrips, films, videotapes, and/or mediated programmed instruction (individual or group) on procedures, techniques, and routines for preparing the patient, the equipment and supplies; checking the solution, starting the intravenous; regulating the flow with or without an IVAC pump; replacing emptied I.V. bottles; irrigating the tubing; adding drugs; monitoring I.V. progress and patient's condition; discontinuing I.V.; fluids commonly used.
3. Hardcover programmed instruction
4. Lecture
5. Discussion
6. Demonstration
7. Practice in simulated patient care unit
8. Study assignments
9. Written exercises
10. Projects
11. Problem solving situations

Training Aids

1. Filmstrips/films/videotapes
2. Mediated programmed instruction
3. Hardcover programmed instruction
4. Slides
5. Wall charts
6. Chalk board
7. Anatomical models
8. Equipment and supplies

9. Instructor's guide
10. Student syllabus
11. References

Examination Modes

1. Response in classroom
2. Paper and pencil test
3. Rating on performance in simulated practice
4. Rating on performance in work situation (feedback)
5. Oral quiz on knowledge related to performance in simulated practice and work situation (feedback)

Training Time

- 1:00 hour didactic
- 0:45 hour supervised practice

LEARNING MODULE 1-14
BLOOD TRANSFUSION: ADMINISTRATION OF

Tasks

- 320328 Cross check medication and treatment card with KARDEX and doctor's orders
- 110063 Verify identification of patient, e.g., for treatment, medication, examination
- 120080 Inform patient of procedure required prior to/during examination/test/treatment
- 120012 Explain physiological basis for therapy/treatment to patient/family
- 120010 Explain/answer patient's questions regarding examination/test/treatment/procedure
- 150141 Elicit information to ascertain patient's understanding of illness/treatment
- 120046 Reassure/calm apprehensive/anxious patient
- 150078 Ask patient/check chart for any contraindications of procedure or test
- 330207 Inform doctor of any contraindications to study
- _____ Wash hands prior to/after patient care, medication, treatment, examination, procedure, and specimen collecting and handling
- 259025 Collect blood by venipuncture
- _____ Prepare, label, and send blood specimen to blood bank/laboratory for typing/cross matching
- 230098 Pick up blood from blood bank
- _____ Check numbers and information on blood, blood tag on patient's bed, and patient's identification bracelet
- _____ Check number on blood container with patient's Blood Transfusion Form, SF518
- 145041 Arrange furniture/set up equipment/supplies for procedure, e.g., examination/treatment
- 240168 Check drugs for visible contamination/deterioration, e.g., cloudiness, color change
- 110081 Position/hold patient for examination, treatment, surgery
- _____ Ascertain that physician counterchecks matching of blood with patient
- _____ Assist doctor in starting transfusion
- 140002 Regulate blood transfusion flow

- 130097 Observe/report symptoms of side effects of treatment/medication
_____ Observe for transfusion reaction, clamp flow, notify nurse/doctor immediately
- 130436 Evaluate patient's complaints or symptoms of pain
- 130382 Observe and record patient's physical/emotional response to treatment/diagnostic procedure
- 130493 Check intravenous site for infiltration, phlebitis, cellulitis
- 150047 Carry out doctor's verbal orders
- 150069 Give/receive verbal reports concerning patient
_____ Discontinue transfusion
- 150064 Write nursing notes
_____ Record on intake and output sheet
_____ Record on TPR graphic chart
_____ Record on nursing care plan
_____ Prepare and send transfusion reports to blood bank/laboratory

Performance Objective (Stimulus)

When assigned by the senior corpsman/technician, nurse, or doctor to assist the physician with a transfusion ordered by the doctor.

Performance Objective (Behavior)

The corpsman/technician will verify the doctor's orders and patient's identity; communicate with the patient about the procedure and treatment and reassure patient if apprehensive or anxious; wash hands; draw and send a blood sample to the blood bank/laboratory for typing and cross-matching; obtain the blood from the blood bank/laboratory; ascertain that blood is for patient receiving it; set up and assist physician in starting transfusion; regulate flow of blood; recognize transfusion reaction and take action; record all actions taken and patient's response; and prepare and submit request and report forms relative to transfusion.

Performance Objective (Conditions)

With supervision and without assistance or with technical assistance for transporting requests, reports, and blood.

Performance Objective (Criteria)

According to established standard procedure, techniques, and routines without error in obtaining correct blood, identification of patient, and procedure for transfusion reaction.

Performance Objective (Consequence)

The patient receives the prescribed transfusion and the correct blood.

Performance Objective (Next Action)

Clean up after the transfusion and make the patient as comfortable as possible.

Knowledge and Skills

1. Purpose of transfusions
2. Anatomy and physiology of blood vessels
3. Blood types
4. Anatomical sites for drawing blood and giving transfusions
5. Sterile technique for drawing blood and giving transfusions
6. Contraindications for transfusions
7. Routine for verification of doctor's orders and patient's identity
8. Patient's disease, therapy, and condition as related to transfusion requirement
9. Communicating with patient to help him understand need for transfusion and procedure in giving so as to mitigate his anxiety.
10. Purpose of washing hands
11. Procedures and techniques for drawing blood for typing, cross matching, and sending to the blood bank or laboratory properly labeled and with the required forms.
12. Routine and procedure for obtaining blood from/for the blood bank or laboratory and verifying patient receiving blood.
13. Procedures and techniques for preparing the patient, the equipment and supplies, and assisting the physician in starting the transfusion.
14. Recognition of symptoms of untoward reaction to blood and institution of countermeasures
15. Monitoring transfusion flow
16. Observation of patient's response to procedure
17. Reporting to doctor, nurse, or senior corpsman/technician progress of transfusion and patient's condition.

18. Recording on patient's record and patient care plan
19. Forwarding required reports to blood bank or laboratory
20. Care or disposal of equipment and supplies

Instructional Strategies

1. Pretest and/or review on anatomy and physiology of the veins and surrounding tissues; veins commonly used for injections; procedure and techniques for drawing blood; sterile techniques; observation and communication techniques; routine for verifying patient's identity and doctor's orders; routines for reporting and recording.
2. Slides, filmstrips, films, videotapes, and/or mediated programmed instruction (individual or group) on procedures, techniques, and routines for drawing and sending blood to blood bank/laboratory for typing and cross matching; obtaining blood from blood bank and verification of blood for patient; setting up and assisting the doctor in starting transfusion; monitoring flow and patient's reaction; transfusion reaction; discontinuing transfusion and handling special transfusion reports.
3. Hardcover programmed instruction
4. Lecture
5. Discussion
6. Demonstration
7. Practice in simulated patient care unit
8. Study assignments
9. Written exercises
10. Case studies
11. Problem solving situations

Training Aids

1. Filmstrips/films/videotapes
2. Mediated programmed instruction
3. Hardcover programmed instruction
4. Slides
5. Chalk board
6. Anatomical models
7. Equipment and supplies
8. Instructor's guide

9. Student syllabus
10. References

Examination Modes

1. Response in classroom
2. Paper and pencil test
3. Rating on performance in simulated practice
4. Rating on performance in work situation (feedback)
5. Oral quiz on knowledge related to performance in simulated practice and work situation (feedback)

Training Time

- 1:00 hour didactic
- 1:00 hour supervised practice

TRAINING UNIT IJ
APPLICATION OF EXTERNAL HEAT AND COLD

Learning Modules

- IJ1. Application of External Heat
- IJ2. Application of External Cold

Learning Objective

Upon completion of this training unit, the learner must be able to apply external heat when ordered by the physician by hot water bottle; heat cradle; clean and sterile hot wet compresses; hot soaks; hot sitz baths; aquamatic K-pac; hydrocollator; and hypo/hyperthermia unit. He must be able to apply external cold by ice bag; clean and sterile cold compresses; perform cold pressor test; give sponge baths and ice pack treatment; and use hypo/hyperthermia unit for cold.

According to the requirements of the treatment or procedure, he must be able to verify the doctor's orders and patient's identity; inform the patient about the treatment or procedure, answer his questions, and reassure him; check for contraindications for the treatment or procedure and be aware of the precautions in performing it; make suggestions for changes in patient care and modify the nursing care plan to reflect any changes; inform his superiors of the patient's condition, treatment, or procedure, and his response to these; and record on the nursing notes and nursing care plan.

The learner must be able to accomplish the foregoing with indirect supervision and with or without an assistant, depending upon the condition of the patient. He must be able to perform the treatment or procedure in accordance with established standard procedures, techniques, and routines.

These actions will result in the patient receiving the application of the cold or heat treatment prescribed by the physician.

Knowledge and Skills

1. Anatomy and physiology of the skin and underlying tissues and capillary circulation
2. Purpose of external heat and cold applications by different methods
3. Communication techniques for giving information to and eliciting it from the patient
4. Observation techniques for assessing the patient's condition and response to his treatment
5. Routine for verification of the doctor's orders and patient's identity
6. Patient's diagnosis, therapy, and condition as related to the treatment
7. Criteria for contraindications for the application of external heat or cold by different methods.
8. Procedures, techniques, and routines for applying external heat by hot water bottle; heat cradle; clean and sterile hot compresses; hot soaks; hot sitz bath, aquamatic K-pac; hydrocollator; and hypo/hyperthermia unit; and for applying external cold by ice bag; clean and sterile ice bag; clean and sterile cold compresses; performing cold pressor test; giving sponge bath; and ice pack treatment; and using hypo/hypothermia unit.
9. Precautionary measures relative to the application of external heat or cold using different methods
10. Routines and procedures for suggesting changes in patient care and for modifying nursing care plan to reflect changes.
11. Routines for reporting and recording treatment or procedure and patient's response to it
12. Routines and procedures for clean-up and care of equipment

Instructional Strategies

1. Pretest and/or review on anatomy and physiology of skin and underlying tissues and capillary circulation; communication and observation skills; verification of doctor's orders and patient's identity; nursing care plan and its modification; reporting and recording.
2. Slides, filmstrips, films, videotapes, and/or mediated programmed instruction (individual or group) on purpose, procedure, technique, and routine for applying external heat by hot water bottle; clean hot wet compresses; hot wet sterile compresses; hot soaks; sitz bath; hydrocollator; aquamatic K-pac; hypo/hyperthermia unit; and external cold by ice bags; clean and sterile cold wet compresses; sponge bath; ice pack; hypo/hyperthermia unit; and performing cold pressor test, including purpose, contraindications, and precautions for each.

3. Hardcover programmed instruction
4. Lecture
5. Discussion
6. Demonstration
7. Practice in simulated patient care unit
8. Study assignments
9. Written exercises

Training Aids

1. Filmstrips/films/videotapes
2. Mediated programmed instruction
3. Hardcover programmed instruction
4. Slides
5. Wall charts
6. Chalk board
7. Anatomical models
8. Equipment and supplies
9. Instructor's guide
10. Student syllabus
11. References

Examination Modes

1. Response in classroom
2. Paper and pencil test
3. Rating on performance in simulated practice
4. Rating on performance in work situation (feedback)
5. Oral quiz on knowledge related to performance in simulated practice and work situation (feedback)

Training Time

3:00 hours didactic

5:00 hours supervised practice

LEARNING MODULE 1J1
APPLICATION OF EXTERNAL HEAT

Tasks

- 320328 Cross check medication and treatment card with KARDEX and doctor's orders
- _____ Wash hands prior to/after patient care, medications, treatment, examination, procedure, specimen collecting and handling
- 110063 Verify identification of patient, e.g., for treatment/medication/examination
- 120080 Inform patient of procedure prior to/during examination/test/treatment
- 150078 Ask patient/check chart for contraindications for treatment/procedure/test
- 120010 Explain/answer patient's questions regarding examination/test/treatment/procedure
- 130436 Evaluate patient's complaints/symptoms of pain
- 120046 Reassure/calm apprehensive/anxious patient
- _____ Apply hot water bottle
- 110027 Assist patient with tub, sitz bath, or shower
- 140031 Apply compresses/soaks/packs
- 140073 Give heat treatment, e.g., hydrocollator, K-pac, heat lamp
- _____ Apply heat by hypo/hyperthermia unit
- 130382 Observe/record patient's physical/emotional response to treatment, diagnostic procedure
- 150035 Give report on changes/special care/treatment/test for patient
- 150013 Make suggestions regarding patient care
- 150082 Suggest changes in nursing care plan for patient
- 150102 Initiate and implement changes in patient's nursing care plan
- 150085 Modify patient care plan according to patient's response and needs, e.g., physical activity
- 150064 Write nursing notes
- _____ Record on nursing care plan

Performance Objective (Stimulus)

When assigned by the senior corpsman/technician, nurse, or doctor to apply external heat as ordered by the physician.

Performance Objective (Behavior)

The corpsman/technician will verify the doctor's orders and the patient's identity; inform the patient about and explain the procedure to him and answer his questions about it; evaluate the patient's complaints and check for any contraindications for the procedure; wash hands; apply hot water bottle; heat cradle; apply hot wet compresses, either clean or sterile; give hot soaks to the extremities; give sitz baths; apply aquamatic K-pac; apply hydrocollator; apply heat by hypo/hyperthermia unit; make suggestions regarding his care; initiate and modify nursing care plan and record on the patient's record and patient care plan.

Performance Objective (Conditions)

With indirect supervision and without assistance, except in the case of a partially or totally helpless patient, when an assistant is required.

Performance Objective (Criteria)

In accordance with established standard procedures and practices.

Performance Objective (Consequence)

Patient will receive the heat treatment prescribed by the physician.

Performance Objective (Next Action)

Make the patient comfortable and check for any untoward reactions.

Knowledge and Skills

1. Purpose of external heat application by different methods
2. Anatomy and physiology of the skin and underlying tissues
3. Communication techniques for giving information to and eliciting it from the patient and for reporting to supervisor
4. Observation techniques to assess patient's condition and reaction to treatment
5. Sterile techniques for applying sterile hot wet compresses
6. Routine for verifying doctor's orders and patient's identity

7. Patient's diagnosis, therapy, and condition as related to treatment
8. Criteria for determining contraindications for treatment
9. Purpose of hand washing
10. Procedures and techniques for applying hot water bottle; heat cradle; clean and sterile hot wet dressings; aquamatic K-pac; hydrocollator; giving sitz bath; hot soaks to the extremities; and applying heat by the hypo/hyperthermia unit; and precautionary measures related to each type of heat application.
11. Procedures and techniques for operating the hydrocollator and hypo/hyperthermia equipment
12. Procedures and techniques for recording on the nursing notes and nursing care plan
13. Procedures and techniques for suggesting changes and initiating and modifying the nursing care plan.
14. Routine for equipment care following use

Instructional Strategies

1. Pretest and/or review on anatomy and physiology of skin and underlying tissues; communication and observation skills; verification of doctor's orders and patient's identity; nursing care plan and its modification.
2. Slides, filmstrips, films, videotapes, and/or mediated programmed instruction (individual or group) on procedures and techniques for applying external heat by hot water bottle; hot wet clean dressings; hot wet sterile dressings; hot soaks; sitz bath; hydrocollator; aquamatic K-pac; and hypo/hyperthermia unit; including purpose, contraindications, and precautions for each.
3. Hardcover programmed instruction
4. Lecture
5. Discussion
6. Demonstration
7. Practice in simulated patient care unit
8. Study assignments
9. Written exercises

Training Aids

1. Filmstrips/films/videotapes
2. Mediated programmed instruction
3. Hardcover programmed instruction

4. Slides
5. Wall charts
6. Chalk board
7. Anatomical models
8. Equipment and supplies
9. Instructor's guide
10. Student syllabus
11. References

Examination Modes

1. Response in classroom
2. Paper and pencil test
3. Rating on performance in simulated practice
4. Rating on performance in work situation (feedback)
5. Oral quiz on knowledge related to performance in simulated practice and/or work situation (feedback)

Training Time

- 1:30 hours didactic
- 2:30 hours supervised practice

LEARNING MODULE 1J2
APPLICATION OF EXTERNAL COLD

Tasks

- 320328 Cross check medication and treatment card with KARDEX and doctor's orders
- _____ Wash hands prior to/after patient care, medications, treatment, examination, procedure, specimen collecting and handling
- 110063 Verify identification of patient, e.g., for treatment/medication/examination
- 120080 Inform patient of procedure prior to/during examination/test/treatment
- 150078 Ask patient/check chart for contraindications for treatment/procedure/test
- 120010 Explain/answer patient's questions regarding examination/test/treatment/procedure
- 130436 Evaluate patient's complaints/symptoms of pain
- 120046 Reassure/calm apprehensive/anxious patient
- _____ Apply ice bag
- 140090 Give sponge bath to reduce fever
- 140031 Apply compresses, soaks, packs
- _____ Perform the cold pressor tests
- _____ Apply cold by hypo/hyperthermia unit
- 140076 Give ice pack treatment
- 130382 Observe/record patient's physical/emotional response to treatment, diagnostic procedure
- 150035 Give report on changes/special care/treatment/test for patient
- 150013 Make suggestions regarding patient care
- 150082 Suggest changes in nursing care plan for patient
- 150102 Initiate and implement changes in patient's nursing care plan
- 150085 Modify patient care plan according to patient's response and needs, e.g., physical activity
- 150064 Write nursing notes
- _____ Record on nursing care plan

Performance Objective (Stimulus)

When assigned by the senior corpsman/technician, nurse, or doctor to apply external cold as ordered by the doctor.

Performance Objective (Behavior)

The corpsman/technician will verify the doctor's orders and the patient's identity; inform the patient about and explain the procedure to him and answer his questions about it; evaluate the patient's complaints and check for any contraindication for the procedure; wash hands; apply ice bag and clean and sterile compresses; perform the cold pressor test; give sponge baths and ice pack treatment; use hypo/hyperthermia unit; make suggestions for changes in patient's care; initiate and modify patient care plan and record on nursing notes and patient care plan.

Performance Objective (Conditions)

With indirect supervision and without assistance, except in the case of a partially or totally helpless patient, when an assistant is required.

Performance Objective (Criteria)

In accordance with established standard procedures and practices.

Performance Objective (Consequence)

Patient will receive the cold treatment prescribed by the physician.

Performance Objective (Next Action)

Make the patient comfortable and check for any untoward reactions.

Knowledge and Skills

1. Purpose of external cold application by different methods
2. Anatomy and physiology of the skin and underlying tissues
3. Communication techniques for giving information to and eliciting it from the patient
4. Observation techniques to assess patient's condition and reaction to treatment

5. Sterile technique for applying sterile cold wet compresses
6. Routine for verifying doctor's orders and patient's identity
7. Patient's diagnosis, therapy, and condition as related to treatment
8. Criteria for determining contraindications to treatment
9. Purpose of hand washing
10. Procedures and techniques for applying ice bags and clean and sterile cold wet compresses, giving a sponge bath, performing cold pressor test, applying cold by the hypo/hyperthermia unit, giving ice pack treatment, and precautionary measures related to each cold treatment.
11. Procedures and techniques for operating hypo/hyperthermia unit
12. Procedures and techniques for recording on the nursing notes and nursing care plan
13. Procedure and techniques for suggesting changes and initiating and modifying the nursing care plan.
14. Routine for equipment care after use

Instructional Strategies

1. Pretest and/or review on anatomy and physiology of the skin and underlying tissues; communication and observation skills; verification of doctor's orders and patient's identity; nursing care plan and its modification; sterile wet dressings.
2. Slides, filmstrips, films, videotapes, and/or mediated programmed instruction (individual or group) on procedures and techniques for applying ice bags and clean and sterile cold wet compresses, giving a sponge bath, performing cold pressor test, giving ice pack treatment and applying cold by the hypo/hyperthermia unit, including purpose, contraindications, and precautions for each.
3. Hardcover programmed instruction
4. Lecture
5. Discussion
6. Demonstration
7. Practice in simulated patient care unit
8. Study assignments
9. Written exercises

Training Aids

1. Filmstrips/films/videotapes
2. Mediated programmed instruction

3. Hardcover programmed instruction
4. Slides
5. Wall charts
6. Chalk board
7. Anatomical models
8. Equipment and supplies
9. Instructor's guide
10. Student syllabus
11. References

Examination Modes

1. Response in classroom
2. Paper and pencil test
3. Rating on performance in simulated practice
4. Rating on performance in work situation (feedback)
5. Oral quiz on knowledge related to performance in simulated practice and/or work situation (feedback)

Training Time

- 1:30 hours didactic
- 2:30 hours supervised practice

TRAINING UNIT IK
CONTROLLING THE SPREAD OF DISEASE AND INFECTION

Learning Modules

- IK1. Putting on Surgical Gloves
- IK2. Using a Face or Surgical Mask
- IK3. Using a Surgical and Isolation Gown
- IK4. Preparation of Isolation Units
- IK5. Isolating and Caring for the Patient
- IK6. Cleaning and Terminal Disinfection of the Isolation Unit

Training Objective

Upon completion of this training unit, the learner must be able to prepare the isolation unit; move the patient into isolation; give the patient care; serve his diet and nourishments; give his medications; give or assist with treatments, tests, and examinations; dispose of body waste and refuse; care for linens and equipment; maintain a clean and neat unit; remove the patient from isolation and perform terminal cleaning and disinfection of the unit.

According to the requirements of the treatment or procedure, he must be able to verify the doctor's orders and patient's identity; inform the patient about the examinations, treatment, or procedure, answer his questions, and reassure him; check for contraindications for the procedure, tests, or examinations and notify his supervisor; make suggestions for changes in patient care and modify the nursing care plan to reflect any changes; inform his supervisor of the patient's condition, care, treatments, tests, and examination and the response to these, and record on the nursing notes and nursing care plan.

The learner must be able to accomplish the foregoing with indirect and selective supervision and with or without technical assistance, depending on the condition of the patient. He must be able to perform according to established standard procedures, techniques, and routines for isolation and without contamination. This action will prevent the spread of infectious diseases.

Knowledge and Skills

1. Purpose of and routines, techniques, and procedures for isolation or medical asepsis
2. Disease for which patients are isolated and any variations of isolation for specific diseases.
3. Communication techniques for giving information to and eliciting it from patient and for reporting to supervisory personnel.
4. Observation techniques for assessing the patient's condition and response to care, treatments, medications, tests, examinations, and isolation routine.
5. Routine for verification of doctor's orders and patient's identity
6. Patient's diagnosis, therapy, and condition as related to isolation techniques, procedures, and routines
7. Criteria for determining contamination
8. Procedures, techniques, and routines for preparing the isolation unit; moving the patient into the unit; giving care, treatments, medications, tests, and examinations to the isolated patient; disposing of body waste and refuse; caring for linen and equipment; maintaining unit cleanliness; removing the patient from isolation; and performing terminal cleaning and disinfection of the unit.
9. Precautionary measures relative to contamination
10. Routines and techniques for suggesting changes in patient care and for modifying nursing care plan to reflect changes.
11. Routines and procedures for clean-up and care of equipment

Instructional Strategies

1. Pretest and/or review on surgical and medical asepsis; bacteria theory; hand washing and scrubbing; communication and observation skills; routines for verifying doctor's orders and patient's identity; routine for reporting and recording.
2. Slides, filmstrips, films, videotapes, and/or mediated programmed instruction (individual or group) on purpose, procedures, techniques, and routines for setting up an isolation unit; gloving, gowning, and masking for patient care; giving patient care, treatments, medications, tests, examinations, or assisting with them in the isolation unit; disposing of body waste and refuse; care of linen and equipment; and terminal cleaning and disinfection of the patient's unit.
3. Hardcover programmed instruction
4. Lecture
5. Discussion

6. Demonstration
7. Practice in simulated patient care unit
8. Study assignments
9. Written exercises

Training Aids

1. Filmstrips/films/videotapes
2. Mediated programmed instruction
3. Hardcover programmed instruction
4. Slides
5. Wall charts
6. Chalk board
7. Anatomical models
8. Equipment and supplies
9. Instructor's guide
10. Student syllabus
11. References

Examination Modes

1. Response in classroom
2. Paper and pencil test
3. Rating on performance in simulated practice
4. Rating on performance in work situation (feedback)
5. Oral quiz on knowledge related to performance in simulated practice and/or work situation (feedback)

Training Time

2:45 hours didactic

4:00 hours supervised practice

LEARNING MODULE IK1
PUTTING ON SURGICAL GLOVES

Tasks

- 145055 Glove for sterile procedure
_____ Glove for isolation, handling contaminated material

Performance Objective (Stimulus)

When assigned by the doctor, nurse, or senior corpsman/technician to assist in performing or to perform a procedure that requires the wearing of surgical gloves.

Performance Objective (Behavior)

The corpsman/technician will glove his washed or scrubbed hands with surgical gloves that are sterile or surgically clean, whichever is appropriate for the work to be performed.

Performance Objective (Conditions)

Without supervision or assistance and without contaminating, puncturing, or tearing the gloves.

Performance Objective (Criteria)

In accordance with established standard procedures, techniques, and routines.

Performance Objective (Consequence)

Hands will be gloved with surgical gloves.

Performance Objective (Next Action)

Proceed with the work to be accomplished.

Knowledge and Skills

1. Purpose of and objectives for wearing surgical gloves
2. Medical and surgical aseptic techniques
3. Procedure, technique, and routines for putting on sterile gloves for surgery and for isolation.

Instructional Strategies

1. Pretest and/or review on skin bacteria as a source of infection; surgical and medical asepsis; hand washing and scrubbing.
2. Slides, filmstrips, films, videotapes, and/or mediated programmed instruction (individual or group) on purpose, procedure, techniques, and routine for putting on surgical gloves for surgery and for isolation.
3. Hardcover programmed instruction
4. Lecture
5. Discussion
6. Demonstration
7. Practice in simulated patient care unit
8. Study assignments
9. Written exercises

Training Aids

1. Filmstrips/films/videotapes
2. Mediated programmed instruction
3. Hardcover programmed instruction
4. Slides
5. Chalk board
6. Equipment and supplies
7. Instructor's guide
8. Student syllabus
9. References

Examination Modes

1. Response in classroom
2. Paper and pencil test
3. Rating on performance in simulated practice
4. Rating on performance in work situation (feedback)
5. Oral quiz on knowledge related to performance in simulated practice and/or work situation (feedback)

Training Time

0:15 hour didactic

0:20 hour supervised practice

LEARNING MODULE IK2
USING A FACE OR SURGICAL MASK

Tasks

_____ Maskings for surgery and for patient care

Performance Objective (Stimulus)

When assigned by the doctor, nurse, or senior corpsman/technician to assist with surgery and when indicated in the working environment for giving patient care.

Performance Objective (Behavior)

The corpsman/technician will use a face mask to protect the patient and/or himself and others from infection.

Performance Objective (Conditions)

Without supervision or assistance.

Performance Objective (Criteria)

In accordance with established standard procedures, techniques, and routines.

Performance Objective (Consequence)

Protection of patient and/or himself and others from infection.

Performance Objective (Next Action)

Proceed with the work to be accomplished.

Knowledge and Skills

1. Medical and surgical asepsis.
2. Purpose and objectives of wearing a (face or surgical) mask
3. Kinds of masks--paper, cloth, regular, special
4. Making an improvised mask
5. Procedures and techniques for putting on, wearing, removing, and disposing of a mask

Instructional Strategies

1. Pretest and/or review on surgical and medical asepsis
2. Slides, filmstrips, films, videotapes, and/or mediated programmed instruction (individual or group) on respiratory tract and environment as sources of infection; kinds of masks; purpose, procedure, technique and routines for putting on, wearing, removing, and disposing of a mask; making an improvised mask.
2. Hardcover programmed instruction
3. Lecture
4. Discussion
5. Demonstration
6. Practice in simulated patient care unit
7. Study assignments
8. Written exercises

Training Aids

1. Filmstrips/films/videotapes
2. Mediated programmed instruction
3. Hardcover programmed instruction
4. Slides
5. Chalk board
6. Equipment and supplies
7. Instructor's guide
8. Student syllabus
9. References

Examination Modes

1. Response in classroom
2. Paper and pencil test
3. Rating on performance in simulated practice
4. Rating on performance in work situation (feedback)
5. Oral quiz on knowledge related to performance in simulated practice and/or work situation (feedback)

Training Time

- 0:10 hour didactic
- 0:10 hour supervised practice

LEARNING MODULE IK3
USING A SURGICAL AND ISOLATION GOWN

Tasks

- 145002 Gown for sterile procedure
_____ Gown for work in isolation unit

Performance Objective (Stimulus)

When assigned by the doctor, nurse, or senior corpsman/technician to assist with a procedure that requires the wearing of a sterile surgical or isolation gown.

Performance Objective (Behavior)

The corpsman/technician will put on, wear, and remove a sterile gown or one used in isolation.

Performance Objective (Conditions)

With selective supervision and without assistance.

Performance Objective (Criteria)

In accordance with established standard procedures, techniques, and routines.

Performance Objective (Consequence)

Gowned in a sterile or isolation gown in accordance with the tasks he is to perform.

Performance Objective (Next Action)

Proceed with the work to be accomplished.

Knowledge and Skills

1. Surgical and medical asepsis
2. Purpose and objectives of sterile gowns and gowns for isolation
3. Kind of gown to be worn
4. Procedure, techniques, and routines for gowning for surgery and for isolation

Instructional Strategies

1. Pretest and/or review on surgical and medical asepsis
2. Slides, filmstrips, films, videotapes, and/or mediated programmed instruction (individual or group) on kind of gown; purpose, procedures, techniques, and routines for gowning for surgery and for isolation; precautions in gowning for surgery and in gowning and degowning for isolation.
2. Hardcover programmed instruction
3. Lecture
4. Discussion
5. Demonstration
6. Practice in simulated patient care unit
7. Study assignments
8. Written exercises

Training Aids

1. Filmstrips/films/videotapes
2. Mediated programmed instruction
3. Hardcover programmed instruction
4. Slides
5. Chalk board
6. Equipment and supplies
7. Instructor's guide
8. Student syllabus
9. References

Examination Modes

1. Response in classroom
2. Paper and pencil test
3. Rating on performance in simulated practice
4. Rating on performance in work situation (feedback)
5. Oral quiz on knowledge related to performance in simulated practice and/or work situation (feedback)

Training Time

0:30 hour didactic

0:30 hour supervised practice

LEARNING MODULE IK4
PREPARATION OF ISOLATION UNITS

Tasks

- 150069 Give/receive verbal orders about patient
- 130066 Screen and isolate patient with suspected communicable disease
- 340116 Prepare isolation room for patient

Performance Objective (Stimulus)

When assigned by the doctor, nurse, or senior corpsman/technician to prepare an isolation room or patient's unit or when an incoming patient has a diagnosis of a contagious or infectious disease.

Performance Objective (Behavior)

The corpsman/technician will prepare the room or unit as a self entity isolated or separated from the remainder of the patient care unit. He will set up the patient's unit, including all equipment and supplies for caring for the patient; for hand washing, or for scrubbing the unit; the gown, and if required, the gloves and the masks. He will place a sign to designate the isolation area. When complete, he will notify his supervisor.

Performance Objective (Conditions)

With indirect supervision and without assistance.

Performance Objective (Criteria)

In accordance with established standard routines, procedures, and techniques.

Performance Objective (Consequence)

A complete unit ready for isolation of the patient with an infectious disease.

Performance Objective (Next Action)

Move the patient into the unit.

Knowledge and Skills

1. Purpose of isolation unit
2. Diseases for which patients are isolated; lists of contagious and infectious diseases
3. Routine, procedure, and techniques for setting up isolation unit, with internal and external running water and without running water.

Instructional Strategies

1. Pretest and/or review on medical asepsis and its significance; hand washing, gowning, gloving, and masking for isolation.
2. Slides, filmstrips, films, videotapes, and/or mediated programmed instruction (individual or group) on contagious and infectious diseases; purpose, routine, procedure, and techniques for setting up an isolation unit with internal and external running water and without running water.
3. Hardcover programmed instruction
4. Lecture
5. Discussion
6. Demonstration
7. Practice in simulated patient care unit
8. Study assignments
9. Written exercises

Training Aids

1. Filmstrips/films/videotapes
2. Mediated programmed instruction
3. Hardcover programmed instruction
4. Chalk board
5. Anatomical models
6. Equipment and supplies
7. Instructor's guide
8. Student syllabus
9. References

Examination Modes

1. Response in classroom
2. Paper and pencil test

3. Rating on performance in simulated practice
4. Rating on performance in work situation (feedback)
5. Oral quiz on knowledge related to performance in simulated practice and/or work situation (feedback)

Training Time

0:20 hour didactic

0:30 hour supervised practice

LEARNING MODULE IK5
ISOLATING AND CARING FOR THE PATIENT

Tasks

- 330328 Cross check medications and treatment card with KARDEX and doctor's orders
- 110063 Verify identification of patient, e.g., for treatments, medications, and examinations
- 120271 Explain isolation/procedure to patient/family
- 120010 Explain/answer patient's questions regarding examination/test/treatment/procedure
- 120091 Explain/answer patient's questions regarding symptoms/disease/treatment
- 150141 Elicit information to ascertain patient's understanding of illness/treatment
- 120046 Reassure/calm apprehensive/anxious patient
- 110121 Move patient into/out of isolation
- _____ Wash hands prior to/after patient care, medications, treatments, examination, procedure, specimen collecting and handling
- 140338 Give care to patient in reverse isolation
- _____ Give care to patient in isolation
- _____ Serve food and nourishment to patient in isolation
- _____ Give medications to patient in isolation
- _____ Give/assist with treatments/examination/tests for patient in isolation
- _____ Dispose of body waste from patient in isolation
- 340044 Pack/wrap up all equipment/supplies/refuse from isolation units before removal
- 130436 Evaluate patient's complaints/symptoms of pain
- 130382 Observe/record patient's physical/emotional response to treatment/diagnostic procedure
- 150013 Make suggestions regarding patient care
- 150082 Suggest changes in nursing care plan for patient
- 150102 Initiate and implement changes in patient's nursing care plan
- 150069 Give/receive verbal reports about patient
- 150035 Give report on changes/special care/treatments/tests for patient
- 150073 Notify medical personnel of treatment needs of patient

- 150036 Inform doctor/nurse of patient's condition, e.g., description of symptoms, injuries, or response
- 150064 Write nursing notes
- _____ Record on nursing care plan

Performance Objective (Stimulus)

When assigned by the doctor, nurse, or senior corpsman/technician to place a patient in isolation; to provide or assist in providing care, treatments, medications, examinations, tests; and to remove a patient from isolation.

Performance Objective (Behavior)

The corpsman/technician will verify the doctor's orders or need to place patient in isolation or reverse isolation; verify the identification of the patient; inform the patient about his placement in isolation or reverse isolation; explain the reason, answer his questions, and reassure him; ascertain that the patient understands; move the patient into the prepared isolation unit and make certain, if he is an ambulatory patient, that he understands the geographical area in which he can move with freedom. For a patient in isolation, the corpsman/technician will give required patient care; serve meals and nourishments; give medications; assist with, give or do treatments, tests, and examinations; dispose of body waste and refuse and care for linen and equipment; inform supervisory personnel of patient's condition, changes in condition, special care or treatment, and patient's response; suggest changes in patient care and modify nursing care plan to reflect any changes, and record on nursing notes. Upon termination of isolation, he will prepare the patient and remove him from isolation.

Performance Objective (Conditions)

With selective supervision and with or without technical assistance, depending on the patient's condition.

Performance Objective (Criteria)

In accordance with established standard procedures, techniques, and routines for moving patient into and out of isolation and maintaining isolation technique in giving the patient care.

Performance Objective (Consequence)

Prevention of spread of infectious diseases.

Performance Objective (Next Action)

Care of contaminated equipment and disposal of contaminated waste from the isolation unit.

Knowledge and Skills

1. Purpose of isolation and reverse isolation
2. Communicable and infectious diseases and how they are spread
3. Communication techniques for giving information to and eliciting it from the patient and for reporting to supervisory personnel.
4. Observation techniques for assessing the patient's condition and response to treatment, care, and to being isolated and for observing breaks in isolation techniques.
5. Routine for verification of doctor's orders and patient's identity
6. Patient's diagnosis, therapy, and condition as related to his care in isolation
7. Procedures, techniques, and routines for placing a patient into and removing him from isolation; giving care, medications, treatments, tests, and examinations in isolation; caring for contaminated equipment and waste; and recording on the nursing notes and patient care plan.
8. Precautionary measures relative to care of ambulatory patient in isolation
9. Routines and techniques for suggesting changes in patient care and for modifying nursing care plan to reflect changes.
10. Routines and procedures for clean-up and care of equipment from isolation unit

Instructional Strategies

1. Pretest and/or review on medical asepsis; isolation hand scrub, gloving, gowning, masking; communication and observation skills; verification of doctor's orders and patient identity; routine for recording and reporting.
2. Slides, filmstrips, films, videotapes, and/or mediated programmed instruction (individual or group) on purpose, procedure, techniques, and routines for placing patient into and removing him from isolation; giving care, medications, treatments, tests, and examinations to the isolated patient; caring for contaminated equipment and waste.

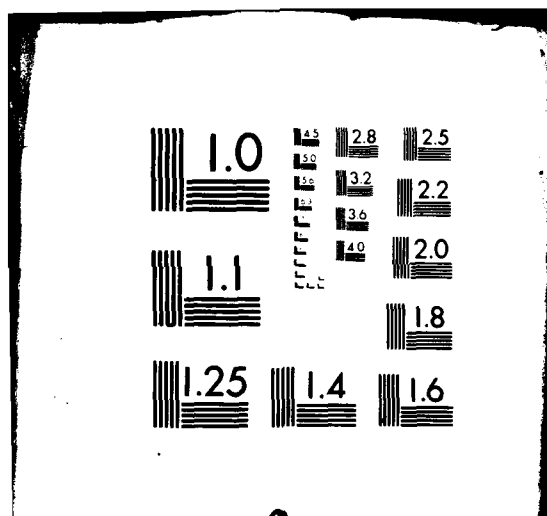
AD-A085 706

TECHNOMICS INC OAKTON VA
A SYSTEM APPROACH TO NAVY MEDICAL EDUCATION AND TRAINING. APPEN--ETC (11)
AUG 74 N00014-69-C-0246
NL

UNCLASSIFIED

4 of 7

AL 0001 0006



3. Hardcover programmed instruction
4. Lecture
5. Discussion
6. Demonstration
7. Practice in simulated patient care unit
8. Study assignments
9. Written exercises

Training Aids

1. Filmstrips/films/videotapes
2. Mediated programmed instruction
3. Hardcover programmed instruction
4. Slides
5. Chalk board
6. Anatomical models
7. Equipment and supplies
8. Instructor's guide
9. Student syllabus
10. References

Examination Modes

1. Response in classroom
2. Paper and pencil test
3. Rating on performance in simulated practice
4. Rating on performance in work situation (feedback)
5. Oral quiz on knowledge related to performance in simulated practice and/or work situation (feedback)

Training Time

0:30 hour didactic

1:00 hour supervised practice

LEARNING MODULE IK6
CLEANING AND TERMINAL DISINFECTION OF THE ISOLATION UNIT

Tasks

- 340050 Do terminal cleaning and disinfection of isolation room or area
340044 Pack/wrap all equipment/supplies/refuse from isolation unit before removal

Performance Objective (Stimulus)

When assigned by the doctor, nurse, or senior corpsman/technician to clean the unit of the patient in isolation or to perform terminal cleaning and disinfection of the isolation unit.

Performance Objective (Behavior)

The corpsman/technician in cleaning the isolation unit will damp dust all room furnishings, clean bathroom fixtures, damp mop the floors, collect all refuse, used supplies, and equipment, pack and wrap them for disposal or sterilization. In performing terminal cleaning and disinfection of the unit, he will strip the unit of all equipment, supplies, and refuse and prepare them for disposal or sterilization; scrub the walls, floor, and room furnishings; arrange and ventilate the unit and leave it unassigned for 2 to 4 hours.

Performance Objective (Conditions)

With selective supervision and without assistance.

Performance Objective (Criteria)

In accordance with procedures, techniques, and routines promulgated by the local activity or established standard ones without contamination of clean areas.

Performance Objective (Consequence)

Clean patient unit ready to be prepared at the end of 2 to 4 hours for the next patient.

Performance Objective (Next Action)

Care of contaminated equipment and linen and disposal of contaminated waste after completion of unit cleaning and disinfection.

Knowledge and Skills

1. Purpose of regular and routine cleaning and of terminal cleaning and disinfection of an isolation unit.
2. Procedures, techniques, and routines for regular and routine cleaning and for terminal cleaning and disinfection of isolation unit.
3. Terminal cleaning and disinfection of isolation units for special infectious diseases, such as gas bacillus.
4. Required time lapse prior to use of unit by next patient

Instructional Strategies

1. Pretest and/or review on medical asepsis; purpose, procedure, techniques, and routines for entering and leaving isolation unit and for caring for contaminated equipment and waste from an isolated unit, and for cleaning patient's unit.
2. Slides, filmstrips, films, videotapes, and/or mediated programmed instruction (individual or group) on purpose, procedures, techniques, and routines for regular routine cleaning of isolation unit and for terminal cleaning and disinfection of isolation unit, including units used for special types of infectious diseases such as gas bacillus.
3. Hardcover programmed instruction
4. Lecture
5. Discussion
6. Demonstration
7. Practice in simulated patient care unit
8. Study assignments
9. Written exercises

Training Aids

1. Filmstrips/films/videotapes
2. Mediated programmed instruction
3. Hardcover programmed instruction
4. Chalk board

5. Equipment and supplies
6. Instructor's guide
7. Student syllabus
8. References

Training Time

0:15 hour didactic
0:30 hour supervised practice

TRAINING UNIT IL
MANAGEMENT OF PATIENT CARE

Learning Modules

- IL1. The Patient's Records: Preparation, Maintenance, and Disposition
- IL2. The Patient's Nursing Care Plan: Preparation, Maintenance, and Disposition
- IL3. The Admission of a Patient to the Ward Unit
- IL4. The Transfer of a Patient Between Ward Units
- IL5. The Discharge of a Patient from the Hospital
- IL6. Doctors Rounds or Sick Call on the Ward Unit
- IL7. Interdepartmental Coordination of Patient Care
- IL8. Patient Care Rounds on the Ward Unit

Learning Objective

Upon completion of the training unit, the learner must be able to open, use, maintain, and close out patients' charts, clinic records, and health records; prepare a nursing assessment and nursing care plan for each patient, to use and modify the Nursing Care Plan and to maintain a current visible file (KARDEX) on all patients; admit, transfer, and discharge a patient; assist with doctors rounds; coordinate consultations, care, and treatments given to patients by other departments; and to make patient rounds on the ward units.

According to the requirements for the routine and procedure, the corpsman/ technician must be able to verify the doctor's orders and patient's identity; inform the patient about the routine and procedure, answer his questions, and reassure him; suggest changes in the patient's care, medications, and treatments and modify the nursing care plan to reflect the changes; report to the doctor, nurse, and/or senior corpsman/technician the patient's condition, changes in his condition, medications, treatments, tests, and examinations given and scheduled and the patient's response to those administered; and record the foregoing information on the appropriate records.

The learner must be able to accomplish the foregoing with selective and indirect supervision or without supervision and with or without assistance, depending on the condition of the patient. He must be able to perform the foregoing according to policies and established standard routines, procedures, and techniques.

The corpsman/technician will be able to manage the admission, transfer, and discharge of patients; the preparation, maintenance, and disposition of patients' records and nursing care plans; and doctors rounds and coordination of patient care by other departments. He will be able to make comprehensive patient care rounds.

Knowledge and Skills

1. Purpose of patients' records; nursing care plan; patient admission, transfer, and discharge routines; doctors rounds; patient care rounds; and coordinating patient care with other departments.
2. Communication techniques for giving information to and eliciting it from the patient, reporting to supervisory personnel, and coordinating patient care with other departments.
3. Observation techniques for assessing patient's condition, symptoms, and response to care, treatments, and medications.
4. Routine for verification of doctor's orders and patient's identity
5. Policies, routines, procedures, and techniques for admitting, transferring, and discharging patients' doctors rounds; patient care rounds; coordinating patient care with other departments; preparing, using, and maintaining nursing care plan; and opening, maintaining, and closing patient's clinical chart, clinic record, and health record.
5. Contraindications and precautions related to the foregoing.

Instructional Strategies

1. Pretest and/or review on observation and communication skills; modification of nursing care plan; recording on patient's chart; preparation and filing of laboratory forms; reporting to supervisory personnel; taking temperature and vital signs; measuring weight and height of patient; cleaning patient's unit; drugs' effects, side effects, and untoward effects; signs of abnormal behavior and symptoms of abnormal conditions.
2. Slides, filmstrips, films, videotapes, and/or mediated programmed instruction (individual or group) on opening, maintaining, and closing of patient's hospital chart, clinic record, and health record; preparing nursing

assessment; preparing, using, and maintaining nursing care plan; admitting, transferring, and discharging a patient; preparing for and making doctors rounds; making patient care rounds; and coordinating patient care with other departments.

3. Hardcover programmed instruction
4. Lecture
5. Discussion
6. Demonstration
7. Role playing
8. Study assignments
9. Written exercises

Training Aids

1. Filmstrips/films/videotapes
2. Mediated programmed instruction
3. Hardcover programmed instruction
4. Chalk board
5. Equipment and supplies
6. Instructor's guide
7. Student syllabus
8. References

Examination Modes

1. Response in classroom
2. Paper and pencil test
3. Rating on performance in simulated practice
4. Rating on performance in work situation (feedback)
5. Oral quiz on knowledge related to performance in simulated practice and/or work situation (feedback)

Training Time

4:30 hours didactic

0:45 hour supervised practice

LEARNING MODULE IL1

THE PATIENT'S RECORDS: PREPARATION, MAINTENANCE, AND DISPOSITION

Tasks

- 330485 Assemble patient's chart, paperwork for new admission/discharge/transfer
- 330494 Enter patient's identification information onto reports/records
- 330071 Assemble charts/requisitions for medical examination
- 150064 Write nursing notes
- 330407 Chart medications onto patient record
- _____ Record on TPR graphic sheet
- 330072 Graph patient data
- 250039 Plot readings/values on rectilinear graph paper
- _____ Record on intake and output sheet
- 320327 Witness/ensure patient's consent and/or if permission has been obtained for treatment, examination, or release
- 330158 Prepare requisitions for diagnostic procedures, e.g., lab, EEG
- 320015 Assess completeness of lab report
- 330023 File completed and returned charts, reports in the patient's record
- 330179 Check patient's chart, health record for complete list of forms, reports, records
- 330111 Maintain daily record on patient's procedures/examinations performed
- 330548 Make entries for elementary physical examination on SF 88, Report of Medical Examination
- 150208 Make entries on SF 600, Chronological Record of Medical Care
- 150055 Review patient's current medical record
- 330001 Maintain medical/dental records

Performance Objective (Stimulus)

When assigned by the doctor, nurse, or senior corpsman/technician the responsibility for the patient's charts, clinic record, and health record.

Performance Objective (Behavior)

In the hospital ward unit, the corpsman/technician will assemble the patient's chart composed of the Standard Form 500 series in chronological order and add to it the required local forms; ascertain on admission of the patient that his

identification data is recorded or stamped by addressograph on each page or form of the chart; review the patient's chart and ensure that the current information is recorded on the nursing notes, TPR record, intake and output record, and various graphic records; ascertain that requests for consultations, tests, and examinations are complete and filed in the chart; ensure that anesthesia and surgery permits are complete and signed; maintain chart so as to prevent invasion of patient's privacy; prepare the charts for discharge or transfer of the patient, and send completed charts of discharged patients to the patients' record office. In the clinic, the corpsman/technician will ensure that the patient's clinical record is complete and in order; maintain record's security and security of record's information; and make the required entries on it. When handling the patient's health record, he will ensure its security and make the required entries.

Performance Objective (Conditions)

With selective supervision and without an assistant.

Performance Objective (Criteria)

In accordance with policies and established standard procedures, techniques, and routines without error.

Performance Objective (Consequence)

Patient's records will be current in information and properly handled.

Knowledge and Skills

1. Purpose and use of patient's chart, clinic record, and health record
2. Composition and sequencing of patient's chart, clinic record, and health record
3. Procedures, techniques, and routines for recording in the patient's chart, clinic record, and health record; preparing requests for consultations, tests, and examinations; completing permission for anesthesia and surgery; filing returned reports; and using addressograph or recording patient's identification data on all records' pages and forms.
4. Opening, maintenance, and disposition of patient's chart, clinic record, and health record.

5. Policies governing the opening, maintenance, and closing of patient's records

Instructional Strategies

1. Pretest and/or review on nursing notes, TPR record, input and output record, and other graph forms; preparing and filing laboratory reports.
2. Slides, filmstrips, films, videotapes, and/or mediated programmed instruction (individual or group) on assembling patient's chart, clinic record, and health record for use; recording on clinic and health records; preparing request for consultations, examinations, and tests; filing returned reports; recording patient's identification data on all records' pages and forms; opening, maintaining, and disposing of patient's chart, clinic record, and health record.
3. Hardcover programmed instruction
4. Lecture
5. Discussion
6. Demonstration
7. Study assignments
8. Written exercises

Training Aids

1. Filmstrips/films/videotapes
2. Mediated programmed instruction
3. Hardcover programmed instruction
4. Chalk board
5. Equipment and supplies
6. Instructor's guide
7. Student syllabus
8. References

Examination Modes

1. Response in classroom
2. Paper and pencil test

3. Rating on performance in work situation (feedback)
4. Oral quiz on knowledge related to performance in simulated practice and/or work situation (feedback)

Training Time

0:45 hour didactic

LEARNING MODULE IL2
THE PATIENT'S NURSING CARE PLAN: PREPARATION,
MAINTENANCE, AND DISPOSITION

Tasks

- 330103 Maintain KARDEX file system
- 150060 Verify/update patient's diagnosis in record/KARDEX
- _____ Prepare a nursing assessment of the patient
- 150028 Prepare a nursing care plan for the patient
- 150082 Suggest changes in nursing care plan for patient
- 150102 Initiate and implement changes in patient's nursing care plan
- 150085 Modify patient care plan according to patient's response/need, e.g., physical activity
- 320328 Cross check medication and treatment card with KARDEX and doctor's orders

Performance Objective (Stimulus)

When assigned by the nurse or senior corpsman/technician to prepare the patient's nursing care plan and in using the nursing care plan.

Performance Objective (Behavior)

The corpsman/technician will complete first the Nursing Assessment (Nav Med 6550/11 (5/73)) form; prepare Nursing Care Plan I (Nav Med 6550/1) and Nursing Care Plan II (Nav Med 6550/1A) and insert the plan in the proper location in the visible file (KARDEX). He will use the plan to plan individual nursing care, communicate pertinent information and evaluate nursing care. He will suggest changes in the plan to meet the patient's needs and modify the plan to reflect these changes and any changes in medications, treatments, tests, examinations, and care.

Performance Objective (Conditions)

With selective supervision and without an assistant.

Performance Objective (Criteria)

In accordance with policies and established standard procedures, techniques, and routines.

Performance Objective (Consequence)

Current nursing care plan for each patient will be available in the KARDEX at all times.

Performance Objective (Next Action)

Check visible file (KARDEX) to ensure that each patient has a nursing care plan.

Knowledge and Skills

1. Purpose, objectives, use, and location of visible file, Nursing Assessment, Nursing Care Plans I and II.
2. Content of visible file, Nursing Assessment, Nursing Care Plans I and II
3. Procedures, techniques, and routines for preparing, modifying, and using KARDEX, Nursing Assessment, Nursing Care Plans I and II.
4. Disposition of Nursing Assessment and nursing care plans.

Instructional Strategies

1. Pretest and/or review on suggesting modification in nursing care plan and modifying plan to reflect changes; communication and observation skills.
2. Slides, filmstrips, films, videotapes, and/or mediated programmed instruction (individual or group) on procedures, techniques, and routines for setting up and using visible file; preparing and using Nursing Assessment; preparing, using, and modifying Nursing Care Plans I and II.
3. Hardcover programmed instruction
4. Lecture
5. Discussion
6. Demonstration
7. Study assignments
8. Written exercises

Training Aids

1. Filmstrips/films/videotapes
2. Mediated programmed instruction
3. Hardcover programmed instruction

4. Chalk board
5. Equipment and supplies
6. Instructor's guide
7. Student syllabus
8. References

Examination Modes

1. Response in classroom
2. Paper and pencil test
3. Rating on performance in work situation (feedback)
4. Oral quiz on knowledge related to performance in simulated practice and/or work situation (feedback)

Training Time

0:45 hour didactic

LEARNING MODULE IL3
THE ADMISSION OF A PATIENT TO THE WARD UNIT

Tasks

- 330536 Act as a receptionist
- 110049 Receive patients on arrival, e.g., introduce self, obtain patient's name
- 150001 Determine bed location within unit
- 150056 Screen patient on arrival to determine who patient should see
- 130081 Obtain preliminary medical history, e.g., past/present complaints, allergies, medications
- 130080 Obtain patient's social and family history
- 120091 Explain/answer patient's questions regarding symptoms/disease/treatment
- 130436 Evaluate patient's complaints/symptoms of pain
- 150141 Elicit information to ascertain patient's understanding of illness/treatment
- 130389 Observe for/report patient's level of physical activity, e.g., lethargy, hyperactivity
- 130264 Observe for symptoms of irritability, restlessness, apprehension
- 130393 Observe and report level of consciousness
- 120080 Inform patient of procedure prior to/during examination/test/treatment
- 120010 Explain/answer patient's questions regarding examination/test/treatment/procedure
- 120046 Reassure/calm apprehensive/anxious patient
- 130016 Check radial (wrist) pulse
- _____ Observe for/report symptoms of abnormal pulse
- 130404 Check/count respirations
- 130099 Observe patient for and describe abnormal respirations
- 130006 Check blood pressure
- 130636 Observe for/report symptoms of hypotension/hypertension
- 130407 Check color of skin, e.g., cyanosis, blanching, jaundice, mottling
- 130110 Perform circulation check, e.g., color, pulse, temperature of skin, capillary return
- 130014 Check patient's temperature
- 130084 Measure/weigh patient or personnel
- 150069 Give/receive verbal reports about patient

- 150073 Notify medical personnel of treatment needs of patient
- 150036 Inform doctor/nurse of patient's condition, e.g., description of symptoms, injuries or response
- 150013 Make suggestions regarding patient care
- 330485 Assemble patient's chart, paperwork for new admission/discharge/transfer
- 330494 Enter patient's identification information onto reports/records
- 330616 Enter into records complaints and symptoms that patient describes
- 150064 Write nursing notes
 - _____ Record on TPR graphic chart
 - _____ Record in TPR book
 - _____ Prepare a Nursing Assessment of the patient
- 150028 Prepare a Nursing Care Plan for the patient

Performance Objective (Stimulus)

When assigned by the doctor, nurse, or senior corpsman/technician to admit a patient to the ward unit.

Performance Objective (Behavior)

The corpsman/technician will greet the patient and initiate the necessary introductions; place the patient in bed and screen him; observe his appearance, behavior, and symptoms; obtain a preliminary medical history; elicit information from him about his condition, answer his questions, and reassure him; evaluate his complaints and symptoms; take his vital signs and temperature; notify the doctor of the patient's admission and inform his supervisor; assemble and prepare the patient's chart; record on the nursing notes, TPR chart, and TPR book; and prepare the patient's nursing assessment and nursing care plan.

Performance Objective (Conditions)

With indirect supervision and with or without an assistant, depending upon the patient's condition.

Performance Objective (Criteria)

According to policies and established standard procedures, techniques, and routines.

Performance Objective (Consequence)

Patient will be properly admitted and ready for the physician to examine.

Performance Objective (Next Action)

Assist the physician in examining the patient and carry out his orders.

Knowledge and Skills

1. Communication techniques for giving information to and eliciting it from the patient and for reporting to supervisory personnel.
2. Observation techniques for examining the patient, assessing his condition, symptoms, and his response to being ill and/or admitted.
3. Policies, procedures, techniques, and routines for taking the patient's temperature and vital signs and recording them; assembling the patient's record and recording the necessary identification data and other information; preparing a nursing assessment and nursing care plan; and notifying the doctor and the nurse about the admission.
4. Policies for assigning patient's room and unit to new admissions

Instructional Strategies

1. Pretest and/or review on communication and observation skills; taking patient's temperature and vital signs; assembling and opening the patient's record; preparing the nursing assessment and nursing care plan; reporting and recording.
2. Slides, filmstrips, films, videotapes, and/or mediated programmed instruction (individual or group) on sequence of events in admitting a patient and difference in admission routines for ambulatory, wheelchair, and stretcher patients.
3. Hardcover programmed instruction
4. Lecture
5. Discussion
6. Demonstration
7. Role playing
8. Practice in simulated patient care unit

9. Study assignments
10. Written exercises

Training Aids

1. Filmstrips/films/videotapes
2. Mediated programmed instruction
3. Hardcover programmed instruction
4. Slides
5. Chalk board
6. Anatomical models
7. Equipment and supplies
8. Instructor's guide
9. Student syllabus
10. References

Examination Modes

1. Response in classroom
2. Paper and pencil test
3. Rating on performance in simulated practice
4. Rating on performance in work situation (feedback)
5. Oral quiz on knowledge related to performance in simulated practice and/or work situation (feedback)

Training Time

- 0:30 hour didactic
- 0:45 hour supervised practice

LEARNING MODULE IL4
THE TRANSFER OF A PATIENT BETWEEN WARD UNITS

Tasks

- 330328 Cross check medication and treatment card with KARDEX and doctor's orders
- 110063 Verify identification of patient, e.g., for treatment, medications, examination
- 120080 Inform patient of procedure prior to/during examination/test/treatment
- 120010 Explain/answer patient's questions regarding examination/test/treatment/procedure
- 120091 Explain/answer patient's questions regarding symptoms/disease/treatment
- 150141 Elicit information to ascertain patient's understanding of illness/treatment
- 120046 Reassure/calm apprehensive/anxious patient
- 330485 Assemble patient's chart, paperwork for new admission/discharge/transfer
- 150099 Give transfer report to ward or receiving unit on patient's condition, treatment, and care plan
- 330495 Coordinate patient transfer within hospital
- 150069 Give/receive verbal reports about patient
- 150064 Write nursing notes
- _____ Record on nursing care plan
- 330413 Assist people in finding clinics and offices
- 330536 Act as a receptionist
- 110049 Receive patients on arrival, e.g., introduce self, obtain patient's name
- 150055 Review patient's current medical record
- 330179 Check patient's chart, health record for complete list of forms, reports, and records

Performance Objective (Stimulus)

When assigned by the doctor, nurse, or senior corpsman/technician to transfer a patient from one ward unit to another one and to admit a patient to a ward unit transferred from another one.

Performance Objective (Behavior)

To transfer the patient to another ward unit, the corpsman/technician will verify the doctor's orders and the patient's identity; notify the ward unit to which the patient is being transferred and give them significant information about the patient, his care, treatments, medications, tests, and examinations; inform the patient about the transfer, answer his questions, and reassure him; collect the patient's records (chart, nursing assessment, nursing care plan, medication cards, and bedside aids) and assemble them for transfer; collect the patient's personal property and prepare him for transfer; record transfer on nursing notes and nursing care plan; transfer the patient, giving instructions as to where he is to go; and notify the history department of the transfer. On receiving a patient transferred from another ward unit, the corpsman/technician will greet the patient and initiate the necessary introductions; assign the patient to a bed; observe his condition and reaction to the transfer; file his records; and notify the doctor and nurse of the patient's arrival.

Performance Objective (Conditions)

Without supervision and with or without an assistant, depending on the patient's condition.

Performance Objective (Criteria)

According to policies and established standard procedures, techniques, and routines.

Performance Objective (Consequence)

Transferred patient will be admitted to the ward unit.

Performance Objective (Next Action)

Make the patient as comfortable as possible.

Knowledge and Skills

1. Communication techniques for giving information to and eliciting it from the patient; reporting to supervisory personnel; and conducting patient's transfer.
2. Observation techniques for assessing the patient's condition
3. Policies, procedures, techniques, and routines for transferring the patient, his personal property, and his records from one hospital ward to another one.

Instructional Strategies

1. Pretest and/or review on communication and observation skills; routines for reporting and recording.
2. Slides, filmstrips, films, videotapes, and/or mediated programmed instruction (individual or group) on policies, procedures, techniques, and routines for transferring a patient from one hospital ward to another one.
3. Hardcover programmed instruction
4. Lecture
5. Discussion
6. Demonstration
7. Study assignments
8. Written exercises

Training Aids

1. Filmstrips/films/videotapes
2. Mediated programmed instruction
3. Hardcover programmed instruction
4. Chalk board
5. Equipment and supplies
6. Instructor's guide
7. Student syllabus
8. References

Examination Modes

1. Response in classroom
2. Paper and pencil test
3. Rating on performance in work situation (feedback)
4. Oral quiz on knowledge related to performance in simulated practice and/or work situation (feedback)

Training Time

0:30 hour didactic

LEARNING MODULE IL5
THE DISCHARGE OF A PATIENT FROM THE HOSPITAL

Tasks

- 330328 Cross check medication and treatment card with KARDEX and doctor's orders
- 110063 Verify identification of patient, e.g., for treatment, medications, examination
- 120080 Inform patient of procedure prior to/during examination/test/treatment
- 120010 Explain/answer patient's questions regarding examination/test/treatment/procedure
- 120083 Counsel patient/family on when and where to seek medical care
- 330485 Assemble patient's charts, paperwork for new admission/discharge/transfer
- 330179 Check patient's chart, health record for complete list of forms, reports, records
- 330023 File completed and returned charts, reports in the patient's record
- 150064 Write nursing notes

Performance Objective (Stimulus)

When assigned by the doctor, nurse, or senior corpsman/technician to carry out the discharge orders for a patient.

Performance Objective (Behavior)

The corpsman/technician will verify the doctor's orders and patient's identity; inform the patient of his discharge, answer his questions, and provide information on required medical follow-up; assemble the patient's chart with standard forms in numerical order and ascertain that it is complete; write discharge note on nursing notes and send to patient affairs office. He will instruct patient on check out procedures and on day of discharge remove patient's name from all ward records; destroy bed tag, medication and treatment card; notify the diet kitchen; and clean the patient's unit.

Performance Objective (Conditions)

Without supervision or assistance.

Performance Objective (Criteria)

According to policies and established routines, procedures, and techniques.

Performance Objective (Consequence)

The patient will be discharged officially with proper disposition of records and cleaning of patient's unit.

Performance Objective (Next Action)

Move to next assignment.

Knowledge and Skills

1. Communication techniques for directing patient's check out and transmitting interdepartmental information.
2. Policies, procedures, techniques, and routines for discharging a patient from the hospital.

Instructional Strategies

1. Pretest and/or review on communication skills; patient's records; cleaning patient's unit.
2. Slides, filmstrips, films, videotapes, and/or mediated programmed instruction (individual or group) on sequence of events in discharging a patient from the hospital.
3. Hardcover programmed instruction
4. Lecture
5. Discussion
6. Demonstration
7. Study assignments
8. Written exercises

Training Aids

1. Filmstrips/films/videotapes
2. Mediated programmed instruction
3. Hardcover programmed instruction
4. Chalk board

5. Equipment and supplies
6. Instructor's guide
7. Student syllabus
8. References

Examination Modes

1. Response in classroom
2. Paper and pencil test
3. Rating on performance in work situation (feedback)
4. Oral quiz on knowledge related to performance in simulated practice and/or work situation (feedback)

Training Time

0:30 hour didactic

LEARNING MODULE IL6
DOCTORS ROUNDS OR SICK CALL ON THE WARD UNIT

Tasks

- 330547 Prepare patients/ward for doctors rounds
- 330071 Assemble chart/requisitions for medical examination
- 330179 Check patient's chart, health record for complete list of forms, reports, records
- 330111 Maintain daily records on patient procedures/examinations performed
- 150062 Verify that doctor's orders are up to date, e.g., treatment, medication orders, fluids
- 240182 Compile list of medications requiring doctor's renewal
- 130083 Make patient rounds/sick call with doctors
- 150013 Make suggestions regarding patient care, e.g., need for medications, treatment
- 130589 Observe for/report symptoms of drug abuse, e.g., acid, speed
- 150017 Recommend need for specialty consults or referral, e.g., dentist
- 150019 Recommend need for paramedical consults or referral, e.g., social worker, O.T., P.T.
- 150080 Make suggestions regarding need for diagnostic tests
- 150107 Write orders in patient's chart for doctor's countersignature
- 150050 Review doctor's orders and instructions with doctor
- 150061 Verify completeness of doctor's orders, e.g., for all routine admissions or preoperative orders
- 240171 Check ordered medication for overdosage and contraindications
- 150054 Obtain clarification of conflicting doctor's orders
- 330158 Prepare requisitions for diagnostic procedures, e.g., lab, EEG
- 330204 Check that consultation request is complete and accurate
- 240157 Notify doctor of errors in prescription
- 150137 Ensure that doctor's orders are carried out

Performance Objective (Stimulus)

When assigned by the doctor, nurse, or senior corpsman/technician to make doctors rounds or sick call.

Performance Objective (Behavior)

The corpsman/technician will check the patient's records for expiring drug orders that require extension, needed modification of ongoing orders, such as diets, and required new orders and list them; assemble the patient's records, needed forms, and examining tray; accompany the doctor and nurse on rounds; provide required information about the patient and make suggestions relative to the patient's needs; and assist with patient's examination. On completion of rounds, he will review the doctor's orders with the doctor for completeness, clarity, and correctness; ensure that the orders are signed, requests for consultations and examinations are properly executed, and prescriptions are completed. He will ensure that all "stat" orders are carried out immediately.

Performance Objective (Conditions)

With indirect supervision and without assistance.

Performance Objective (Criteria)

According to policies and established standard procedures, techniques, and routines.

Performance Objective (Consequence)

Doctor's orders to meet patient's needs.

Performance Objective (Next Action)

Transcription of doctor's orders.

Knowledge and Skills

1. Communication techniques for providing information to doctor for rounds or sick call.
2. Observation techniques for assessing the patient's condition and response to therapy.
3. Use of patient's chart, medication and treatment card, and nursing care plan to provide data for doctors rounds or sick call.

4. Purpose, routine, procedures, and techniques for doctors rounds or sick call and the preparation of requests for consultation, examination, and tests.
5. Required content of doctor's orders
6. Laws, policies, and routines that govern drugs, treatments, etc., requiring doctor's orders and that govern the issuing of doctor's orders.

Instructional Strategies

1. Pretest and/or review on communication and observation skills; patient's records
2. Slides, filmstrips, films, videotapes, and/or mediated programmed instruction (individual or group) on routine, procedures, and techniques for setting up examination tray; making doctors rounds or sick call.
3. Hardcover programmed instruction
4. Lecture
5. Discussion
6. Demonstration
7. Study assignments
8. Written exercises

Training Aids

1. Filmstrips/films/videotapes
2. Mediated programmed instruction
3. Hardcover programmed instruction
4. Chalk board
5. Equipment and supplies
6. Instructor's guide
7. Student syllabus
8. References

Examination Modes

1. Response in classroom
2. Paper and pencil test
3. Rating on performance in work situation (feedback)

4. Oral quiz on knowledge related to performance in simulated practice and/or work situation (feedback)

Training Time

0:30 hour didactic

LEARNING MODULE IL7
INTERDEPARTMENTAL COORDINATION OF PATIENT CARE

Tasks

- 330204 Check that consultation request is complete and accurate
- 150092 Confer with paramedical personnel to discuss patient progress/problems, e.g., O.T., P.T., social occupational therapy, physical therapy, social workers
- 150133 Coordinate patient treatment plan with other departments/agencies
- 150088 Follow up on referral to determine if patient obtained appropriate service
- 150011 Confer with the chaplain to discuss patient/family needs/problems
- 330410 Adjust/coordinate changes in patient's schedule as needed

Performance Objective (Stimulus)

When assigned by the doctor, nurse, or senior corpsman/technician to coordinate consultations, care, and treatments administered by other departments to a patient from a ward unit.

Performance Objective (Behavior)

The corpsman/technician will ensure that complete and correct requests are sent to the other departments; the departments are provided any additional data necessary to providing consultation, care, and treatments; appointment schedules are established and maintained; progress reports are submitted from the departments to the ward unit; and the patients' reactions and responses to the consultations, care, and treatments.

Performance Objective (Conditions)

Without supervision or assistance.

Performance Objective (Criteria)

According to policies and established standard routines, procedures, and techniques.

Performance Objective (Consequence)

The patients receive the consultations, care, and treatments needed and/or ordered.

Performance Objective (Next Action)

Inform the doctor, nurse, or senior corpsman/technician of the patients' progress, problems, and needs resulting from the consultations, care, and treatments administered by other department.

Knowledge and Skills

1. Purpose of initiating and following up on interdepartment consultations, care, and treatment.
2. Communication techniques necessary to interdepartmental coordination
3. Routines for reporting and recording coordination efforts

Instructional Strategies

1. Pretest and/or review on communication skills; routines for reporting and recording.
2. Slides, filmstrips, films, videotapes, and/or mediated programmed instruction (individual or group) on purpose, routine, procedures, and techniques for coordination of consultations, care, and treatments done by other departments for patients.
3. Hardcover programmed instruction
4. Lecture
5. Discussion
6. Practice in work situation
7. Study assignments

Training Aids

1. Filmstrips/films/videotapes
2. Mediated programmed instruction
3. Hardcover programmed instruction
4. Chalk board
5. Equipment and supplies

6. Instructor's guide
7. Student syllabus
8. References

Examination Modes

1. Response in classroom
2. Paper and pencil test
3. Rating on performance in work situation (feedback)
4. Oral quiz on knowledge related to performance in simulated practice and/or work situation (feedback)

Training Time

0:30 hour didactic

LEARNING MODULE IL8
PATIENT CARE ROUNDS ON THE WARD UNIT

Tasks

- 330328 Cross check medication and treatment card with KARDEX and doctor's orders
- 110063 Verify identification of patient, e.g., for treatment, medications, examination
- 130082 Make patient rounds of ward/station/unit/hospital
- 120010 Explain/answer patient's questions regarding examination/test/treatment/procedure
- 120091 Explain/answer patient's questions regarding symptoms/disease/treatment
- 150141 Elicit information to ascertain patient's understanding of illness/treatment
- 120046 Reassure/calm apprehensive/anxious patient
- 130436 Evaluate patient's complaints/symptoms of pain
- 120004 Reinforce patient's positive response to therapy
- 120293 Progressively lessen patient's dependency on medical personnel
- 120036 Encourage patient's independence and involvement in self care
- 150069 Give/receive verbal reports about patient
- 150013 Make suggestions regarding patient care
- 150082 Suggest changes in nursing care plan for patient
- 150102 Initiate and implement changes in patient's nursing care plan
- 150035 Give report on changes/special care/treatment/tests for patient
- 150073 Notify medical personnel of treatment needs of patient
- 150036 Inform doctor/nurse of patient's condition, e.g., description of symptoms, injuries or response
- 150064 Write nursing notes

Performance Objective (Stimulus)

When assigned by the doctor, nurse, or senior corpsman/technician to make patient rounds and when assigned the responsibility for a unit of patients.

Performance Objective (Behavior)

The corpsman/technician will be familiar with patient's condition and therapy, verify the patient's identity and doctor's orders for each patient; make patient rounds by visiting each patient and observing his condition, changes in condition, physiological and emotional response to care, medications, treatments, tests, examinations, and procedures, and his symptoms and abnormalities. He will communicate with the patient (if conscious) about his condition, therapy, and needs; administer required treatment; and give encouragement to him. He will notify the doctor or nurse about significant changes in the patient's condition and his needs. He will record his findings and action taken on the nursing notes and, if necessary, modify the nursing care plan to reflect changes in care.

Performance Objective (Conditions)

Without supervision or assistance.

Performance Objective (Criteria)

According to policies and established routines, procedures, and techniques.

Performance Objective (Consequence)

Status of each patient in the unit will be known and required care, treatment, and medications will be administered.

Performance Objective (Next Action)

Proceed with patient care, medications, and treatments.

Knowledge and Skills

1. Purpose, routine, procedure, and techniques for making patient rounds
2. Symptoms of diseases and conditions for which observation is to be made (Learning Module ID1).
3. Information which is to be communicated to the patient, the nurse, and the doctor (Learning Module ID2).
4. Observation and communication routines, procedures, and techniques

5. Patient's diagnosis, therapy, and condition in evaluating status at a given time
6. Routine for verification of doctor's orders and patient's identity
7. Contraindications or precautions in administering care, medications, treatments, or carrying out a procedure which seems indicated as a result of patient rounds.
8. Routines, procedures, and techniques for reporting and recording

Instructional Strategies

1. Pretest and/or review on communication and observation skills; routine for verifying doctor's orders and patient's identity; routines for reporting and recording; temperature and vital signs; drug effects, side effects, and untoward effects; signs of abnormal behavior.
2. Slides, filmstrips, films, videotapes, and/or mediated programmed instruction (individual or group) on purpose, routine, procedures, and techniques for making patient rounds.
3. Hardcover programmed instruction
4. Lecture
5. Discussion
6. Study assignments
7. Written exercises

Training Aids

1. Filmstrips/films/videotapes
2. Mediated programmed instruction
3. Hardcover programmed instruction
4. Chalk board
5. Instructor's guide
6. Student syllabus
7. References

Examination Modes

1. Response in classroom
2. Paper and pencil test
3. Rating on performance in work situation (feedback)

4. Oral quiz on knowledge related to performance in simulated practice and/or work situation (feedback)

Training Time

0:30 hour didactic

TRAINING UNIT IM
EMERGENCIES: EXAMINATION AND TREATMENT

Learning Modules

- IM1. Convulsions: Examination and Emergency Treatment
- IM2. Unconsciousness: Examination and Emergency Treatment
- IM3. Inebriation: Examination and Emergency Treatment
- IM4. Food Poisoning: Examination and Emergency Treatment
- IM5. Poisoning: Examination and Emergency Treatment
- IM6. Respiratory Emergencies: Examination of
- IM7. Respiratory Emergencies: Treatment for Obstructions and Mechanical Interferences
- IM8. Respiratory Emergencies: Administration of Artificial Respiration
- IM9. Application of Binders, Bandages, and Strapping
- IM10. Hemorrhage: Examination of
- IM11. Hemorrhage: Emergency Treatment for
- IM12. Shock: Examination for
- IM13. Shock: Emergency Treatment for
- IM14. Wounds: Emergency Treatment for
- IM15. Wounds: Emergency Suturing of
- IM16. Internal Injuries: Examination for
- IM17. Internal Injuries: Emergency Treatment for
- IM18. Strains, Sprains, and Dislocations: Examination and Emergency Treatment
- IM19. Fractures: Examination and Emergency Treatment for
- IM20. Spinal Cord and Head Injuries: Examination and Emergency Treatment
- IM21. Burns: Examination and Emergency Treatment
- IM22. Heat Cramps, Heat Exhaustion, and Heat Stroke: Examination and Emergency Treatment
- IM23. Cold Injury: Examination and Emergency Treatment
- IM24. Bites and Stings: Examination of
- IM25. Bites and Stings: Emergency Treatment for
- IM26. Acute Heart Conditions: Examination of
- IM27. Acute Heart Conditions: Treatment for
- IM28. Moving and Transporting Emergency Cases

Training Objective

Upon completion of this training unit, the learner must be able to diagnose and give emergency treatment for convulsions; diabetic coma; insulin coma (shock); uremic coma; apoplexy; inebriation; food poisoning from ingestion of poisonous foods and bacterially poisoned foods; poisoning from ingestion of poisons, drugs, and chemicals and inhalation of poisonous gases and smoke, as listed on standard poison and antidotal charts; respiratory obstructions and mechanical interference, including administering artificial respiration; hemorrhage; shock; internal injuries; strains, sprains, and dislocations; fractures; spinal cord and head injuries; burns; heat cramps, exhaustion, and strokes; frostbite; bites and stings; acute cardiac conditions, including cardiac arrest; and various types of wounds, including emergency suturing. He must be able to apply binders, bandages, and strapping required for emergency treatment and to triage, move, and transport emergency cases.

According to the kind and degree of the emergency, the learner must be able to obtain an initial medical history; verify the identity of the patient or victim; inform the patient or victim (if conscious) and his family and friends about the examination and/or required emergency treatment and reassure him or them; check for contraindications for moving, positioning, and treating the patient or victim; inform medical personnel about the patient's condition, response to treatment, and needs; and prepare the appropriate records and reports on the case.

He must be able to accomplish the foregoing without supervision and with or without assistance, depending on the condition of the patient.

The learner must be able to perform the foregoing according to established standard emergency routines, procedures, and techniques applied in the hospital and on ambulance calls.

The patient or victim will receive an emergency diagnosis and will be rendered emergency treatment according to the diagnosis.

The action subsequent to emergency treatment is the referral of the victim or patient to medical personnel for further treatment or his release to his own care and the necessary clean up and readying of supplies and equipment for the next emergency call or case.

Knowledge and Skills

1. Anatomy and physiology of the body systems
2. Causes of the emergency
3. Routine for verification of the patient's identity
4. Communication techniques for eliciting information from and giving it to the patient or victim and his family and friends and reassuring them.
5. Observation techniques for assessing the patient's or victim's symptoms, condition, and response to treatment.
6. Treatment required by the emergency diagnosis
7. Contraindications for moving and positioning the patient or victim and for treating him.
8. Procedures, techniques, and routines for examining and giving emergency treatment for convulsions; coma; inebriation; food poisoning; poisoning by ingestion or inhalation of drugs, chemicals, gases, and smoke; respiratory obstructions and mechanical interference; hemorrhage; shock; internal injuries; strains, sprains, and dislocations; fractures; spinal cord and head injuries; burns; heat cramps, exhaustion, and strokes; frostbite; bites and stings; acute cardiac conditions, including cardiac arrest; and various types of wounds, including emergency suturing. Also procedures, techniques, and routines for applying binders, bandages, and strapping and for triaging, moving, and transporting emergency cases.
9. Precautionary measures relative to making a diagnosis and treating an emergency case.
10. Routines for reporting to medical personnel and recording on appropriate records.

Instructional Strategies

1. Pretest and/or review on communication and observation skills; routines for reporting and recording; routine for identifying patient or victim; anatomy and physiology of the body systems, organs, and tissues. Procedures, techniques, and routines for taking the vital signs; performing skin, circulatory, and neurological checks; observing vomitus, sputum, excreta, urine, and drainage from body cavities and its significance to the emergency case; application of body restraints; positioning and moving patients; administration of medications; encouraging oral fluid intake; giving retention enemas; changing soiled clothing and linens; hand washing and scrubbing; and putting on surgical gloves.

2. Slides, filmstrips, films, videotapes, and/or mediated programmed instruction (individual or group) on causes, symptoms, and emergency treatment for convulsions; coma; respiratory obstruction and mechanical interference; inebriation; poisoning by food, drugs, chemicals, and gases; hemorrhage; shock; wounds; internal injuries; strains, sprains, and dislocations; fractures; spinal cord and head injuries; burns; heat cramps, exhaustion, and strokes; frostbite; bites and stings; and acute cardiac conditions, including cardiac arrest. Procedures, techniques, and routines for applying binders, bandages, and strapping and for moving and transporting emergency cases.
3. Hardcover programmed instruction
4. Lecture
5. Discussion
6. Demonstration
7. Practice in simulated patient care unit
8. Study assignments
9. Written exercises
10. Case studies

Training Aids

1. Filmstrips/films/videotapes
2. Mediated programmed instruction
3. Hardcover programmed instruction
4. Slides
5. Wall charts
6. Chalk board
7. Anatomical models
8. Equipment and supplies
9. Instructor's guide
10. Student syllabus
11. References

Examination Modes

1. Response in classroom
2. Paper and pencil test
3. Rating on performance in simulated practice

4. Rating on performance in work situation (feedback)
5. Oral quiz on knowledge related to performance in simulated practice and/or work situation (feedback)
6. Case studies

Training Time

24:15 hours didactic

30:50 hours supervised practice

LEARNING MODULE IM1
CONVULSIONS: EXAMINATION AND EMERGENCY TREATMENT

Tasks

- 130437 Observe/describe or report characteristics of convulsions/seizures
- 130081 Obtain preliminary medical history, e.g., past/present complaints, allergies, medications
- 130404 Check/count respirations
- 130099 Observe patient for and describe abnormal respirations
- 130112 Perform neurological (cranic) check: pupils, vital signs, patient's response
- 130588 Observe for, describe or report characteristics of twitching, tremors, tics
- 130435 Observe/report patient's muscle tone, e.g., rigid, flaccid, spastic, spasms
- 130407 Check color of skin, e.g., cyanosis, blanching, jaundice, mottling
- 130110 Perform circulation check, e.g., color, pulse, temperature of skin, capillary return
- 130393 Observe and report level of consciousness
- 130388 Observe/report or describe characteristics of urine, feces, vomitus, regurgitation
- 150143 Initiate treatment procedures in the absence of a doctor
- 110063 Verify identification of patient, e.g., for treatment, medications, examination
- 120080 Inform patient of procedure prior to/during examination/test/treatment
- 120010 Explain/answer patient's questions regarding examination/test/treatment/procedure
- 120091 Explain/answer patient's questions regarding symptoms/disease/treatment
- 150141 Elicit information to ascertain patient's understanding of illness/treatment
- 130436 Evaluate patient's complaints/symptoms of pain
- 120046 Reassure/calm apprehensive/anxious patient
- 140041 Give emergency treatment/first aid for a convulsion
- _____ Loosen clothing, e.g., collar, waistband, belt
- 110145 Restrain patient with an armhold
- 110052 Restrain patient, e.g., linen, leather strap, Posie belt, blanket wrap

- _____ Prevent aspiration of mucus, vomitus, etc.
- _____ Prevent patient from biting tongue
- _____ Keep victim quiet, warm, comfortable as possible
- 140279 Force fluid intake
- 150069 Give/receive verbal reports about patient
- 150036 Inform doctor/nurse of patient's condition, e.g., description of symptoms, injuries or response
- 150073 Notify medical personnel of treatment needs of patient
- 150064 Write nursing notes
- 150208 Make entry on Standard Form 600, "Chronological Record of Medical Care"

Performance Objective (Stimulus)

When in response to an ambulance call or within a medical facility and a doctor, nurse, or senior corpsman/technician is not present and a patient or victim appears to be having a convulsion.

Performance Objective (Behavior)

The corpsman/technician will examine the patient or victim for the following symptoms: loss of consciousness and falling; foaming at mouth; severe convulsive spasms of jaw muscles; convulsive movement of head, eyes, extremities, body; livid face; swollen neck veins; clenched teeth; loud labored breathing with hissing sounds; incontinence of urine and/or feces and vomiting. The corpsman/technician will give emergency treatment: prevent victim from injuring himself by applying necessary restraint; prevent biting of tongue; prevent aspiration of vomitus or mucus; and on return to consciousness, protect victim from embarrassment caused by onlookers and give fluids by mouth.

Performance Objective (Conditions)

Without supervision and with or without an assistant, depending on the condition of the patient or victim.

Performance Objective (Criteria)

In accordance with established standard procedures, techniques, and routines.

Performance Objective (Consequence)

Examination and emergency treatment of patient or victim with a convulsion or seizure.

Performance Objective (Next Action)

Refer to medical personnel for further treatment, unless epileptic with petit mal, then release in own custody when competent for self protection.

Knowledge and Skills

1. Causes of convulsions or seizures and types of epileptic seizures
2. Routine for verification of patient's identity
3. Communication techniques for giving information to and eliciting information from the patient and for reporting to supervisory personnel.
4. Observation techniques for assessing the patient's condition and response to emergency treatment of convulsions or seizures.
5. Patient's diagnosis and condition as related to his convulsion and treatment of it.
6. Procedures, techniques, and routines for obtaining preliminary medical history; verifying patient's or victim's identity; counting and describing respirations; performing skin, circulatory, and neurological check; observing and describing level of consciousness, convulsive movement, vomiting, and incontinence; preventing body injury, tongue biting, and aspiration; and preparing appropriate reports.
7. Precautionary measures relative to prevention of tongue biting and aspiration and the disposition of patient or victim.

Instructional Strategies

1. Procedures, techniques, and routines for counting and describing respirations; performing skin and circulation check; observing and describing vomiting and incontinence; application of body restraints; and recording on appropriate hospital records. Also, observation and communication skills.
2. Causes of convulsions and precautionary measures in treatment; procedures, techniques, and routines for obtaining preliminary medical history as related to emergency treatment; performing neurological check; determining level of consciousness; identifying and describing convulsive movements; preventing aspiration; and preparing emergency reports.
3. Hardcover programmed instruction
4. Lecture

5. Discussion
6. Demonstration
7. Practice in work situation
8. Study assignments
9. Written exercises

Training Aids

1. Filmstrips/films/videotapes
2. Mediated programmed instruction
3. Hardcover programmed instruction
4. Slides
5. Chalk board
6. Anatomical models
7. Equipment and supplies
8. Instructor's guide
9. Student syllabus
10. References

Examination Modes

1. Response in classroom
2. Paper and pencil test
3. Rating on performance in work situation (feedback)
4. Oral quiz on knowledge related to performance in simulated practice and/or work situation (feedback)

Training Time

- 0:45 hour didactic
- 0:45 hour supervised practice

LEARNING MODULE IM2
UNCONSCIOUSNESS: EXAMINATION AND EMERGENCY TREATMENT

Tasks

- 130081 Obtain preliminary medical history, e.g., past/present complaints, allergies, medications
- _____ Observe for/report symptoms of diabetic coma
- 130255 Observe for/report symptoms of insulin reaction
- _____ Observe for/report symptoms of apoplexy (stroke)
- 130407 Check color of skin, e.g., cyanosis, blanching, jaundice, mottling
- 130110 Perform circulation check, e.g., color, pulse, temperature of skin, capillary return
- 130404 Check/count respirations
- 130099 Observe patient for and describe abnormal respirations
- 130016 Check radial (wrist) pulse
- 130010 Check femoral pulse
- 130011 Check pedal pulse
- _____ Observe for/report symptoms of abnormal pulse
- 130409 Check temperature of skin
- 130014 Check patient's temperature
- 130100 Observe patient for signs of chilling
- 130410 Check for sweating/diaphoresis
- 130006 Check blood pressure
- 130636 Observe for/report symptoms of hypotension/hypertension
- 130264 Observe for symptoms of irritability, restlessness, apprehension
- 130112 Perform neurological (cranic) check: pupils, vital signs, patient's response
- 130442 Check swallowing reflex
- 130443 Check blink reflex
- 130435 Observe/report patient's muscle tone, e.g., rigid, flaccid, spastic, spasm
- 130588 Observe for, describe, or report characteristics of twitching, tremors, tics
- 130437 Observe/describe or report characteristics of convulsions/seizures
- _____ Observe/record or describe unusual odors about body waste, e.g., breath, perspiration, urine, stool, vomitus, sputum

130388 Observe/record or describe characteristics of urine, feces, vomitus, regurgitation
 130393 Observe and report level of consciousness
 130059 Observe for/report symptoms of shock
 130436 Evaluate patient's complaints/symptoms of pain
 110063 Verify identification of patient, e.g., for treatment, medications, examination
 120080 Inform patient of procedure prior to/during examination/test/treatment
 150078 Ask patient/check chart for contraindications for treatment/procedure/test
 120010 Explain/answer patient's questions regarding examination/test/treatment/procedure
 120091 Explain/answer patient's questions regarding symptoms/disease/treatment
 150141 Elicit information to ascertain patient's understanding of illness/treatment
 120046 Reassure/calm apprehensive/anxious patient
 150143 Initiate treatment procedure in absence of doctor
 _____ Loosen clothing, e.g., collar, waistband, belt
 _____ Assist patient/move patient into prone, supine, Sim's, Fowler's position
 110093 Position patient in body alignment with adequate support
 _____ Keep victim quiet, warm, comfortable as possible
 140031 Apply compresses/soaks/pads
 140011 Administer subcutaneous medication
 140279 Force fluid intake
 110004 Feed or help patient in eating
 140322 Give medical/retention enema, e.g., oil retention
 110145 Restrain patient with an armhold
 110052 Restrain patient, e.g., linen, leather straps, Posie belt, blanket wrap
 _____ Prevent aspiration of mucus, vomitus, etc.
 _____ Prevent patient from biting tongue
 140041 Give emergency treatment or first aid for a convulsion
 140047 Give emergency treatment or first aid for shock
 150069 Give/receive verbal reports about patient
 150036 Inform doctor/nurse of patient's condition, e.g., description of symptoms, injuries or response

150073 Notify medical personnel of treatment needs of patient
150064 Write nursing notes
150208 Make entry on Standard Form 600, "Chronological Record of Medical Care"

Performance Objective (Stimulus)

When in response to an ambulance call or within a medical facility and a doctor, nurse, or senior corpsman/technician is not present and a patient or victim is unconscious.

Performance Objective (Behavior)

The corpsman/technician will examine the patient and victim to determine the cause of the unconsciousness and be familiar with the signs and symptoms of coma caused by diabetes, insulin, apoplexy, and uremia. He will give emergency treatment for each of these conditions.

Performance Objective (Conditions)

Without supervision and with or without an assistant, depending on the condition of the patient or victim.

Performance Objective (Criteria)

In accordance with established standard procedures, techniques, and routines.

Performance Objective (Consequence)

The unconscious patient or victim will be diagnosed and receive emergency treatment.

Performance Objective (Next Action)

Transfer patient or victim to medical personnel for further treatment.

Knowledge and Skills

1. Causes of unconsciousness
2. Routine for verifying patient's or victim's identity
3. Communication techniques for giving information to and eliciting information from the patient and for reporting to supervisory personnel.

4. Observation techniques for assessing the cause of patient's or victim's unconsciousness and his response to emergency treatment.
5. Patient's diagnosis and level of consciousness as related to his emergency treatment
6. Procedures, techniques and routines for taking preliminary medical history; determining cause and level of unconsciousness, and giving emergency treatment:

Diabetic coma--Signs and symptoms: face flushed, cherry red lips, dry skin, lowered temperature, spasmodic breathing, acetone (nail polish) breath, and vomiting. Treatment: insulin, water or plain tea by mouth, and salt or soda bicarbonate retention enema.

Insulin coma--Signs and symptoms: ash white color, moist clammy skin, cold sweat, rapid pulse, and shallow breathing. Treatment: sugar lumps or orange juice by mouth and retention enema of concentrated sugar water.

Apoplexy--Signs and symptoms: sudden onset, headache, maybe dizziness and mental confusion, high blood pressure, collapse, face red and congested, neck veins bulging, eyes prominent, pupils unequal in size, dropping of one side of mouth, drooling of saliva, vomiting, convulsions, and paralysis. Treatment: semireclining position, comfortable as possible, loosen clothing, apply cold wet compresses to forehead and face, keep quiet, assist with vomiting to prevent aspiration and treat convulsions.

Uremia--Signs and symptoms: headache, drowsy, confused, sallow lemon color, cold and dry skin, rapid breathing, rapid full bounding pulse, generalized stale body odor of old urine, uriniferous breath, and coma progresses from light to deep. Treatment: transfer to medical care.

7. Precaution in the interpretation of medical history, signs, and symptoms

Instructional Strategies

1. Pretest and/or review on procedures, techniques, and routines for counting and describing respirations and pulse; taking blood pressure; obtaining preliminary medical history; verifying patient's identity; performing skin, circulatory, and neurological checks; determining level of consciousness; restraining patient or victim as necessary during convulsion, prevention of tongue biting and aspiration, and preparing appropriate reports.
2. Slides, filmstrips, films, videotapes, and/or mediated programmed instruction (individual or group) on causes of unconsciousness, signs, symptoms, and emergency treatment for diabetic coma, insulin coma (shock), apoplexy, and uremic coma.

3. Hardcover programmed instruction
4. Lecture
5. Discussion
6. Demonstration
7. Practice in simulated patient care unit
8. Study assignments
9. Written exercises
10. Case studies

Training Aids

1. Filmstrips/films/videotapes
2. Mediated programmed instruction
3. Hardcover programmed instruction
4. Slides
5. Chalk board
6. Equipment and supplies
7. Instructor's guide
8. Student syllabus
9. References

Examination Modes

1. Response in classroom
2. Paper and pencil test
3. Rating on performance in simulated practice
4. Rating on performance in work situation (feedback)
5. Oral quiz on knowledge related to performance in simulated practice and/or work situation (feedback)
6. Case studies

Training Time

0:30 hour didactic

0:45 hour supervised practice

LEARNING MODULE 1M3

INEBRIATION: EXAMINATION AND EMERGENCY TREATMENT

Tasks

- 130039 Observe for/report symptoms of hangover
- 130438 Observe for/report symptoms of inebriation (drunkenness)
- 130027 Observe for/report symptoms of delirium tremens
- 110063 Verify identification of patient, e.g., for treatment, medication, examination
- 130374 Observe patient's general emotional condition, e.g., facial and eye expressions, quality of voice
- 130377 Orientation to time, place, and person
- 130094 Identify/describe manifestations of loss of contact with reality, e.g., hallucinations, delusions
- 130407 Check color of skin, e.g., cyanosis, blanching, jaundice, mottling
- 130112 Perform neurological (cranial) check: pupils, vital signs, patient's response
- 130441 Check elbow/knee jerks, i.e., bicep/patellar reflex
- 130442 Check swallowing reflex
- 130443 Check blink reflex
- 130388 Observe/record or describe characteristics of urine, feces, vomitus, regurgitation
- 110053 Restrain/control patient verbally
- 120046 Reassure/calm apprehensive/anxious patient
- 120004 Reinforce patient's positive response to therapy
- _____ Observe/record or describe unusual odors about body waste, e.g., breath, perspiration, urine, stool, vomitus, sputum
- 130393 Observe and report level of consciousness
- 130059 Observe for/report symptoms of shock
- 150143 Initiate treatment procedure in the absence of a doctor
- 140279 Force fluid intake
- 140478 Initiate nursing measures to prevent DTs, e.g., sedate patient, force fluids
- _____ Induce vomiting
- 140323 Lavage stomach, i.e., irrigate until clear
- 140085 Give oral medications
- 140322 Give medical/retention enema, e.g., oil retention
- 110096 Change patient's soiled linen and clothing

- 140047 Give emergency treatment or first aid for shock
- 150069 Give/receive verbal reports about patient
- 150073 Notify medical personnel of treatment needs of patient
- 150036 Inform doctor/nurse of patient's condition, e.g., description of symptoms, injuries or response
- 150064 Write nursing notes
- 150208 Make entry on Standard Form 600, "Chronological Record of Medical Care"

Performance Objective (Stimulus)

When in response to an ambulance call or within a medical facility and a doctor, nurse, or senior corpsman/technician is not present and a patient or victim appears to be inebriated.

Performance Objective (Behavior)

The corpsman/technician will examine the patient or victim to determine the presence and degree of drunkenness and the required treatment. He will observe that the patient or victim has a loss of inhibitions; has impaired judgment; slowed reflexes; impaired coordination; white or pale color; cold sweat; and an alcoholic breath; may be semiconscious or unconscious; and may show symptoms of shock. He will, depending on the degree of inebriation, use tact in dealing with him (agree with him); induce vomiting; lavage stomach; give saline cathartic; force fluids (large amounts of black coffee with sugar); give spirits of ammonia inhalation; give aromatic ammonia orally; treat shock and if absolutely necessary give paraldehyde orally or rectally.

Performance Objective (Conditions)

Without supervision and with or without an assistant, depending on the condition of the patient.

Performance Objective (Criteria)

In accordance with established standard procedures, techniques, and routines.

Performance Objective (Consequence)

Inebriated patient will be diagnosed and given emergency treatment.

Performance Objective (Next Action)

Refer patient to medical personnel for further treatment.

Knowledge and Skills

1. Anatomy and physiology of the digestive, circulatory, and nervous systems and the impact of alcohol intake on these systems.
2. Communication techniques for giving information to and eliciting information from the patient and for reporting to supervisory personnel.
3. Observation techniques for assessing the patient's condition and response to treatment for acute alcoholism.
4. Routine for verification of patient's identity
5. Patient's degree of inebriation as related to required emergency treatment
6. Procedures, techniques, and routines for obtaining the inebriated patient's cooperation; promoting elimination of alcohol from his system; changing soiled linen and clothing; replacing body fluids; administering medications orally, rectally, and by inhalation; and treating shock.
7. Precautions in giving paraldehyde. Do not give sedatives.
8. Routines for recording on appropriate records.

Instructional Strategies

1. Pretest and/or review on communication and observation skills; administration of medications orally, rectally, and by inhalation; forcing fluids; routines for verifying patient's identity; changing soiled clothing and linen; routines for reporting and recording.
2. Slides, filmstrips, films, videotapes, and/or mediated programmed instruction (individual or group) on procedures, techniques, and routines for inducing vomiting and lavaging stomach.
3. Hardcover programmed instruction
4. Lecture
5. Discussion
6. Demonstration
7. Practice in simulated patient care unit
8. Study assignments
9. Written exercises

Training Aids

1. Filmstrips/films/videotapes
2. Mediated programmed instruction
3. Hardcover programmed instruction
4. Slides
5. Chalk board
6. Anatomical models
7. Equipment and supplies
8. Instructor's guide
9. Student syllabus
10. References

Examination Modes

1. Response in classroom
2. Paper and pencil test
3. Rating on performance in simulated practice
4. Rating on performance in work situation (feedback)
5. Oral quiz on knowledge related to performance in simulated practice and/or work situation (feedback)

Training Time

- 0:30 hour didactic
- 0:45 hour supervised practice

LEARNING MODULE IM4
FOOD POISONING: EXAMINATION AND EMERGENCY TREATMENT

Tasks

- 130081 Obtain preliminary medical history, e.g., past/present complaints, allergies, medications
- 130024 Observe for/report symptoms of food poisoning
- 130027 Observe for/report symptoms of diarrhea
- 130388 Observe/record or describe characteristics of urine, feces, vomitus, or regurgitation
- 130404 Check/count respirations
- 130099 Observe patient for and describe abnormal respirations
- 130016 Check radial (wrist) pulse
- 130010 Check femoral pulse
- 130011 Check pedal pulse
- _____ Observe for/report symptoms of abnormal pulse
- 130110 Perform circulation check, e.g., color, pulse, temperature of skin, capillary return
- 130014 Check patient's temperature
- 130407 Check color of skin, e.g., cyanosis, blanching, jaundice, mottling
- 130485 Examine and describe characteristics of hives and rashes
- 130483 Examine for symptoms of atopic dermatitis
- 130410 Check for sweating/diaphoresis
- 130100 Observe patient for signs of chilling
- 130240 Check for edema (swelling) of extremities and eyes
- _____ Check lacrimation
- _____ Check salivation
- 130436 Evaluate patient's complaints/symptoms of pain
- 130393 Observe and report levels of consciousness
- 130112 Perform neurological (cranic) check: pupils, vital signs, patient's response
- 130435 Observe/report patient's muscle tone, e.g., rigid, flaccid, spastic, spasm
- 130442 Check swallowing reflex
- _____ Observe for and report symptoms of convulsions

- 130494 Observe for/report or describe visual disturbances, e.g., blurred, double, mirror, tunnel
- 130094 Identify/describe manifestations of loss of contact with reality, e.g., hallucinations, delusions
- 130059 Observe for and report symptoms of shock
- 110063 Verify identification of patient, e.g., for treatment, medications, examination
- 120080 Inform patient of procedure prior to/during examination/test/treatment
- 120010 Explain/answer patient's questions regarding examination/test/treatment/procedure
- 120091 Explain/answer patient's questions regarding symptoms/disease/treatment
- 150141 Elicit information to ascertain patient's understanding of illness/treatment
- 120046 Reassure/calm apprehensive/anxious patient
- 120088 Reassure/calm children for examination or treatment
- 120085 Reassure apprehensive parents of pediatric patient
- 150143 Initiate treatment procedure in the absence of a doctor
- 140085 Give oral medication
- 140011 Administer subcutaneous medications
- 140012 Give sublingual/buccal medication
- 110052 Restrain patient, e.g., linen, leather straps, Posie belt, blanket wrap
- 140047 Give emergency treatment or first aid for shock
- _____ Perform an emergency tracheotomy
- 110096 Change patient's soiled linen and clothing
- 150069 Give/receive verbal reports about patient
- 150036 Inform doctor/nurse of patient's condition, e.g., description of symptoms, injuries or response
- 150073 Notify medical personnel of treatment needs of patient
- 150064 Write nursing notes
- 150208 Make entry on Standard Form 600 "Chronological Record of Medical Care"

Performance Objective (Stimulus)

When in response to an ambulance call or within a medical facility and a doctor, nurse, or senior corpsman/technician is not present and a patient or victim appears to have food poisoning.

Performance Objective (Behavior)

The corpsman/technician will obtain a preliminary medical history, especially as related to recent and unusual food intake; count the pulse and respiration and observe for abnormalities; observe skin color and examine for hives, rashes, edema, increased salivation and tearing; note presence and extent of diaphoresis and chilling, unconsciousness and symptoms of shock; examine for contracted pupils, dimming vision, paralysis of throat muscles, speech difficulty, and hallucinations; and observe for convulsion symptoms. While examining, he will obtain as much information about the patient or victim as possible, answer his, his family's, and his friends' questions and reassure them. He will initiate treatment, depending on the cause of the food poisoning, which may include the administering of medications; restraining the patient for safety; providing high carbohydrate intake; treating convulsions and shock; preventing aspiration; and performing a tracheotomy.

Performance Objective (Conditions)

Without supervision and with or without an assistant, depending upon the patient's condition.

Performance Objective (Criteria)

In accordance with established standard procedures, techniques, and routines for identifying specific food poisons and treating them.

Performance Objective (Consequence)

Victim of food poisoning will receive correct emergency treatment.

Performance Objective (Next Action)

Refer victim to medical personnel for further care.

Knowledge and Skills

1. Types of food poisoning - naturally poisonous foods and bacterially poisoned foods.

2. Naturally poisonous foods most frequently ingested, symptoms and treatment:

Shellfish poisoning--Symptoms: violent gastrointestinal upset, generalized, blotchy, reddish-blue rash with severe itching; generalized swelling; asthma; and sometimes convulsions. Treatment: epsom salts orally; antihistamine drugs; and tracheotomy if larynx swells and closes. Medical attention is urgent.

Mushroom poisoning--Symptoms (depend on kind of mushroom): for *Amanita phalloides*, onset several hours after eating; abdominal pain, diarrhea, and vomiting; attacks come in bouts with intervening periods of remission; after 24 hours shock, convulsions, followed by death in few days; for *Amanita muscaria*, onset few hours after eating; violent vomiting; diarrhea; flow of tears; excessive salivation; profuse sweating; difficult breathing; slow pulse; contracted pupils; hallucinations; death from respiratory paralysis within 2 days. Treatment: absolute rest; empty stomach; treat shock and convulsions; and restrain. For *Amanita muscaria* give atropine tablet (gr 1/150) sublingual every 1 to 2 hours. Medical attention is urgent.

3. Bacterially poisoned foods resulting in most serious illness:

Staphylococcal food poisoning--Symptoms: onset few hours after eating, nausea, vomiting, abdominal pain, diarrhea, rarely a fever--commonly called "intestinal gripe." Treatment: no immediate emergency unless shock is impending or has occurred.

Salmonella food poisoning--Symptoms: onset 8 or more hours after eating, nausea, abdominal cramps, severe watery diarrhea, and fever of about 102°F. Treatment: no immediate emergency.

Botulism--Symptoms: onset 2 days after ingestion of food, gastrointestinal upset, dimness of vision followed by double vision; difficulty talking and swallowing; paralysis of throat muscles followed by choking. Death due to strangulation or heart failure. Treatment: no emergency. Medical treatment is urgent.

4. Communication techniques for giving information to and eliciting information from the patient and for reporting to supervisory personnel.
5. Routine for identifying patient
6. Observation techniques for assessing the patient's condition and response to emergency treatment if required.
7. Procedures, techniques, and routines for counting pulse and respiration and identifying abnormalities; examining for skin abnormalities, diaphoresis, chilling, edema, excessive salivation and tearing; levels of consciousness, shock, convulsions, and paralysis; keeping patient clean; administering medications orally, sublingually, and subcutaneously; restraining patient or victim; treating convulsions and shock; preventing aspiration; and performing a tracheotomy.

8. Precautionary measures relative to performing a tracheotomy
9. Routines for recording findings and emergency treatment on appropriate records
10. Routines and procedures for clean up and care of equipment

Instructional Strategies

1. Pretest and/or review on communication and observation skills; routine for identifying the patient; routines for reporting and recording; routines, procedures, and techniques for checking pulse and respiration; performing skin, circulation, and neurological check; treating shock and convulsions; and identifying levels of consciousness.
2. Slides, filmstrips, films, videotapes, and/or mediated programmed instruction (individual or group) on types of food poisoning; symptoms and emergency treatment for shellfish and mushroom poisoning; staphylococcal, salmonella, and botulism food poisoning.
3. Hardcover programmed instruction
4. Lecture
5. Discussion
6. Demonstration
7. Practice in simulated patient care unit
8. Study assignments
9. Written exercises
10. Case studies

Training Aids

1. Filmstrips/films/videotapes
2. Mediated programmed instruction
3. Hardcover programmed instruction
4. Slides
5. Wall charts
6. Chalk board
7. Equipment and supplies
8. Instructor's guide
9. Student syllabus
10. References

Examination Modes

1. Response in classroom
2. Paper and pencil test
3. Rating on performance in simulated practice
4. Rating on performance in work situation (feedback)
5. Oral quiz on knowledge related to performance in simulated practice and/or work situation (feedback)
6. Case studies

Training Time

0:30 hour didactic
0:30 hour supervised practice

LEARNING MODULE IM5
POISONING: EXAMINATION AND EMERGENCY TREATMENT

Tasks

- 150143 Initiate treatment procedures in the absence of a doctor
- 130081 Obtain preliminary medical history, i.e., past/present complaints, allergies and medications
- 130036 Observe for/report symptoms of drug/chemical/alcohol ingestion (poisoning)
- 140046 Give emergency treatment/first aid for severe drug/alcohol reaction
- 140463 Give emergency treatment/first aid for chemical ingestion poisoning
- 140509 Give emergency treatment/first aid for carbon dioxide poisoning
- 140510 Give emergency treatment/first aid for carbon monoxide poisoning
- 140460 Give emergency treatment/first aid for smoke inhalation
- 130388 Observe/record or describe characteristics of urine, feces, vomitus, or regurgitation
- 130425 Observe/record or describe characteristics of sputum, mucus
- 130407 Check color of skin, e.g., cyanosis, blanching, jaundice, mottling
- 130110 Perform circulation check, e.g., color, pulse, temperature of skin, capillary return
- 130006 Check blood pressure
- 130015 Check pupil reaction to light
- 130112 Perform neurological (cranial) check, e.g., pupils, vital signs, patient's response
- 130404 Check and count respirations
- 130099 Observe patient for and describe abnormal respirations
- 130264 Observe for symptoms of irritability, restlessness, apprehension
- 130437 Observe/describe or report characteristics of convulsions, seizures
- 130393 Observe and report patient's level of consciousness
- 130436 Evaluate patient's complaints/symptoms of pain
- 140463 Give emergency treatment/first aid for drug/chemical ingestion/poisoning
- 140085 Give oral medications
- 140011 Administer subcutaneous injection
- 140005 Administer intramuscular injection
- 140039 Give emergency treatment/first aid for respiratory impairment

- 140047 Give emergency treatment/first aid for shock
- 140086 Give oxygen therapy, i.e., cannula, catheter/mask
- _____ Keep victim quiet, warm, and as comfortable as possible
- 140076 Give ice pack treatment
- 140323 Lavage stomach, i.e., irrigate until clear
- 120046 Reassure/calm apprehensive/anxious patient
- 120088 Reassure/calm children for examination or treatment
- 120085 Reassure/calm parents of pediatric patient
- 150036 Inform doctor/nurse of patient's conditions, e.g., description of symptoms, injury or response
- 150073 Notify medical personnel of treatment needs of patient
- 150064 Write nursing notes
- 150208 Make entry on SF600 "Chronological Record of Medical Care"

Performance Objective (Stimulus)

When an individual has ingested, inhaled, or absorbed a possible poison and a physician, nurse, or senior corpsman/technician is not present.

Performance Objective (Behavior)

The corpsman/technician will obtain a history of the poison intake and the container from which the poison was obtained; examine for the kind of poison by determining the color and condition of the skin, especially stains and burns of the mouth and lips; the rate, kind, and rhythm of the victim's pulse and respirations; the location and kind of pain; the reaction of the pupils; irritability, restlessness, apprehension; level of consciousness; blood pressure; odor of breath; symptom of impending shock or presence of shock; presence and characteristics of convulsions; and characteristics of emesis or sputum. He will reassure the apprehensive patient or victim, the family and friends; institute treatment to eliminate the poison from the body and/or to neutralize it and treat shock, respiratory failure, and convulsions if present. He will notify medical personnel of the victim's history, symptoms, condition, treatment, and response and record on the patient's record. In the case of ingested poisons, he will save all emesis for chemical analysis.

Performance Objective (Conditions)

Without supervision and with or without assistance, depending on the victim's condition and availability of assistants.

Performance Objective (Criteria)

In accordance with established procedures, techniques, and routines.

Performance Objective (Consequence)

Identification of kind of poison ingested, inhaled, and/or absorbed and give emergency treatment for it.

Performance Objective (Next Action)

Transfer the patient or victim to physician's care as soon as possible.

Knowledge and Skills

1. How poisons enter the body and their action on the body
2. General procedure for treating victims of ingested non-corrosive poisons
3. Signs, symptoms, and treatment of different types of poisons, such as corrosive acids and alkalies, depressant drugs, irritant substances, drugs commonly found in household, carbon monoxide, carbon tetrachloride, kerosene, insecticides, rodenticides, cyanide and methyl (wood) alcohol; hydrogen sulfide, methane, sulfur dioxide, smoke, and others listed on standard poison and antidotal charts.
4. Communication techniques for eliciting information from victim, family, friends about kind of poison, giving information and reassurance to them and directing assistants.
5. Observation techniques for assessing victim's symptoms, condition, and response to treatment.
6. Use of the "Poison and Antidotal Chart" and Poison Control Center
7. Routine for notifying medical personnel in hospital and non-hospital environment about patient or victim.
8. Routine for recording history, symptoms, condition, treatment, and response of victim on appropriate records.

Instructional Strategies

1. Pretest and/or review on observation and communication skills; examination procedure for vital signs, skin symptoms and pupil reaction; level of consciousness; recognition and treatment of respiratory failure and shock; routines for reporting and recording.

2. Slides, filmstrips, films, videotapes, and/or mediated programmed instruction (individual or group) on procedures, techniques, and routines for examining for and treating ingested, inhaled, and absorbed poisons and convulsions and precautions in treatment. Availability and use of Poison and Antidotal Charts (toxicology charts) and Poison Control Center.
3. Hardcover programmed instruction
4. Lecture
5. Discussion
6. Demonstration
7. Practice in simulated patient care unit
8. Study assignments
9. Written exercises
10. Case studies

Training Aids

1. Filmstrips/films/videotapes
2. Mediated programmed instruction
3. Hardcover programmed instruction
4. Slides
5. Chalk board
6. Wall charts--"Poison and Antidotal Chart"
7. Equipment and supplies
8. Instructor's guide
9. Student syllabus
10. References

Examination Modes

1. Response in classroom
2. Paper and pencil test
3. Rating on performance in simulated practice
4. Rating on performance in work situation (feedback)

5. Oral quiz on knowledge related to performance in simulated practice and/or work situation (feedback)
6. Case studies

Training Time

1:30 hours didactic

1:30 hours supervised practice

LEARNING MODULE IM6
RESPIRATORY EMERGENCIES: EXAMINATION OF

Tasks

- 130404 Check/count respirations
- 130097 Observe patient for and describe abnormal respirations
- 130016 Check radial (wrist) pulse
- 130407 Check color of skin, e.g., cyanosis, blanching, jaundice, mottling
- 130015 Check pupil reaction to light
- 130081 Obtain preliminary medical history, e.g., past/present complaints, allergies, medications
- 130405 Observe for/report characteristics of cough
- 130273 Observe for/report symptoms of aspiration
- 130264 Observe for/report or describe symptoms of irritability, restlessness, apprehension
- 130436 Evaluate patient's complaints/symptoms of pain
- 130393 Observe and report patient's level of consciousness
- 120046 Reassure/calm apprehensive/anxious patient
- 120088 Reassure/calm children for examination or treatment
- 120085 Reassure apprehensive parents of pediatric patient
- 150036 Inform doctor/nurse of patient's condition, e.g., description of symptoms, injury or response
- 150073 Notify medical personnel of treatment needs of patient
- 150064 Write nursing notes
- 150208 Make entry on SF600 "Chronological Record of Medical Care"

Performance Objective (Stimulus)

When an individual is showing signs and symptoms of respiratory embarrassment or difficulty and in the absence of a doctor, nurse, or senior corpsman/technician.

Performance Objective (Behavior)

The corpsman/technician will identify a respiratory emergency as being in the early or later stage and the type of emergency as determined by the

report of problem, rate and type of respirations and pulse, skin color, pain, pupil reactions and level of consciousness, will report to appropriate medical personnel on the victim's symptoms and condition and record same in hospital or non-hospital records.

Performance Objective (Conditions)

Without supervision or assistance.

Performance Objective (Criteria)

Recognizing the signs and symptoms and interpreting them into the proper context.

Performance Objective (Consequence)

An accurate evaluation of respiratory symptoms and status of the emergency.

Performance Objective (Next Action)

Treat the emergency.

Knowledge and Skills

1. Anatomy and physiology of the respiratory tract as related to other body functions
2. Signs and symptoms of respiratory emergency in the early states: shortness of breath, rapid pulse, mild dizziness, and chest pain; in the later stages: increasing irregular breathing, bluish purple skin color, dilated pupils, and loss of consciousness; in an obstruction: difficult breathing with head thrown back, eyes bulging, abdomen bulging with diaphragm contracted downward, lower chest and depression below collar-bone sucked in, and face a mottled bluish red; and in mechanical interference with breathing, a cessation of breathing due to chest compression.
3. Communication techniques for eliciting information from the victim and/or family or friends and for giving instructions and encouragement to him and/or them.
4. Observation techniques for assessing the respiratory emergency
5. Routine for reporting to medical personnel in a hospital and non-hospital environment
6. Routine for recording examination findings in a hospital and non-hospital environment.

Instructional Strategies

1. Pretest and/or review on anatomy and physiology of respiratory tract; normal and abnormal pulse and respirations; normal and abnormal skin color; symptoms of apprehension and anxiety; communication and observation skills.
2. Slides, filmstrips, films, videotapes, and/or mediated programmed instruction (individual or group) on history, signs and symptoms of respiratory obstruction by foreign body and aspiration; identification of external mechanical interference; reporting and recording on hospital and on non-hospital patients.
3. Hardcover programmed instruction
4. Lecture
5. Discussion
6. Demonstration
7. Practice in simulated patient care unit
8. Study assignments
9. Written exercises
10. Case studies

Training Aids

1. Filmstrips/films/videotapes
2. Mediated programmed instruction
3. Hardcover programmed instruction
4. Slides
5. Chalk board
6. Instructor's guide
7. Student syllabus
8. References

Examination Modes

1. Response in classroom
2. Paper and pencil test
3. Rating on performance in work situation (feedback)

4. Oral quiz on knowledge related to performance in simulated practice and/or work situation (feedback)
5. Case studies

Training Time

0:30 hour didactic

0:30 hour supervised practice

LEARNING MODULE IM7
RESPIRATORY EMERGENCIES: TREATMENT FOR OBSTRUCTIONS
AND MECHANICAL INTERFERENCES

Tasks

- 150143 Initiate treatment procedure in the absence of a doctor
- 110123 Position patient who has difficulty breathing
- 140039 Give emergency treatment/first aid for respiratory impairment
- 130012 Check patient for prosthesis, e.g., teeth
- 140500 Remove superficial foreign body from nose
- 140157 Remove superficial foreign body from throat
- 140276 Suction nasal/oral passage
- 140172 Suction trachea, i.e., deep endotracheal suction
- 140277 Insert needle in trachea to maintain airway
- _____ Perform an emergency tracheotomy
- 140378 Place patient in postural drainage position
- 130436 Evaluate patient's complaints/symptoms of pain
- 120046 Reassure/calm apprehensive/anxious patient
- 120088 Reassure/calm children for examination or treatment
- 120085 Reassure apprehensive parents of pediatric patient
- 150036 Inform doctor/nurse of patient's condition, e.g., description of symptoms, injury or response
- 150073 Notify medical personnel of treatment needs of patient
- 150064 Write nursing notes
- 150208 Make entry on SF600 "Chronological Record of Medical Care"

Performance Objective (Stimulus)

When an individual has been examined and is found to have a respiratory tract obstruction or a mechanical interference; a doctor, nurse, or senior corpsman/technician is not present; and medical assistance is being awaited.

Performance Objective (Behavior)

The corpsman/technician, having recognized a respiratory emergency caused by an obstruction, will endeavor to remove the foreign bodies, such as food,

vomit and mucus, and water, in case of drowning, from the respiratory tract and to reduce swollen vocal cords. If unsuccessful in removing obstruction, he will perform an emergency tracheotomy. In the case of mechanical interference with breathing, such as victim buried in debris, he will free the victim from the debris. He will elicit needed information from the victim, family and/or friends and give instructions and encouragement to the victim, family and/or friends. In all cases, hospital and non-hospital, he will report victim's symptoms, needs, and treatment to medical personnel and will record symptoms and treatment on the appropriate hospital or non-hospital records.

Performance Objective (Conditions)

Without supervision and with an assistant or technical assistant as needed and available.

Performance Objective (Criteria)

According to established standard procedures, techniques, and routines for giving immediate treatment.

Performance Objective (Consequence)

Either removal of respiratory obstruction or mechanical interference to breathing or death, the results dependent to a great extent on the proficiency of care.

Performance Objective (Next Action)

Administration of artificial respiration if needed or making the patient as comfortable as possible.

Knowledge and Skills

1. Anatomy and physiology of the respiratory tract as related to respiratory tract; respiratory obstructions and mechanical interference with breathing.
2. Treatment for foreign body from respiratory tract: if superficial and can be manually reached, then remove without pushing further into air passage; if not superficial, then place upper portion of the body vertically downward and strike hard sharp blows between shoulder blades.

3. Treatment for removing foreign material such as vomitus and mucus; place upper portion of body downward, pull tongue forward and suction.
4. Treatment for drowning: place body with head and thorax downward and give Holger Nielsen's type of artificial respiration.
5. Treatment for swollen vocal cords: treat as to cause such as anaphylactic shock and rush to medical care.
6. Treatment for mechanical interference: free victim as rapidly as possible
7. Procedures and techniques for emergency tracheotomy to be done as last resort in all obstructions except drowning.
8. Observation techniques for continuous evaluation of victim's condition and response to treatment.
9. Communication techniques for eliciting information from victim, family, and friends, directing assistants and giving instructions and reassuring victim, family, and/or friends.
10. Routine for reporting to medical personnel in a hospital or non-hospital environment
11. Routine for recording victim's condition and treatment in a hospital and non-hospital environment.

Instructional Strategies

1. Pretest and/or review on anatomy and physiology of respiratory tract; signs and symptoms of respiratory obstruction and mechanical interference; communication and observation skills; reporting to medical personnel in hospital and in emergency situations; recording on hospital patients and emergency victims.
2. Slides, filmstrips, films, videotapes, and/or mediated programmed instruction (individual or group) on purpose, procedures, techniques, and routines for removing from the respiratory tract foreign bodies, such as food, foreign material, such as vomitus, water from drowning; for freeing victim from mechanical interference such as debris; and performing an emergency tracheotomy.
3. Hardcover programmed instruction
4. Lecture
5. Discussion
6. Demonstration
7. Practice in simulated patient care unit
8. Study assignments
9. Written exercises

Training Aids

1. Filmstrips/films/videotapes
2. Mediated programmed instruction
3. Hardcover programmed instruction
4. Slides
5. Chalk board
6. Wall charts
7. Anatomical models
8. Equipment and supplies
9. Instructor's guide
10. Student syllabus
11. References

Examination Modes

1. Response in classroom
2. Paper and pencil test
3. Rating on performance in simulated practice
4. Rating on performance in work situation (feedback)
5. Oral quiz on knowledge related to performance in simulated practice and/or work situation (feedback)

Training Time

- 1:30 hours didactic
- 3:00 hours supervised practice

LEARNING MODULE IM8

RESPIRATORY EMERGENCIES: ADMINISTRATION OF ARTIFICIAL RESPIRATION

Tasks

- 150143 Initiate treatment procedure in the absence of a doctor
- 140039 Give emergency treatment/first aid for respiratory impairments
- 130012 Check patient for prosthesis, e.g., teeth
- 140500 Remove superficial foreign body from nose
- 140157 Remove superficial foreign body from throat
- 140276 Suction nasal/oral passage
- 140172 Suction trachea, i.e., deep endotracheal suction
- 130436 Evaluate patient's complaints/symptoms of pain
- 110123 Position patient who has difficulty breathing
- 140159 Resuscitate patient using arm lift or hand-back technique
- 140161 Resuscitate patient using mouth to mouth technique
- 140480 Insert airway
- 130019 Check patient's airway for patency/obstruction
- 342108 Inspect breathing masks (oxygen or gas) for malfunction
- 140160 Resuscitate patient using Ambu bag
- 140162 Resuscitate patient using respirator
- 120046 Reassure/calm apprehensive/anxious patient
- 120088 Reassure/calm children for examination or treatment
- 120085 Reassure apprehensive parents of pediatric patient
- 150036 Inform doctor/nurse of patient's condition, e.g., description of symptoms, injury or response
- 150073 Notify medical personnel of treatment needs of patient
- 150064 Write nursing notes
- 150208 Make entry on SF600 "Chronological Record of Medical Care"

Performance Objective (Stimulus)

When an individual has been observed and examined and respiratory tract obstruction or mechanical interference has been relieved; a doctor, nurse, or emergency technician is not present; and medical assistance is being awaited.

Performance Objective (Behavior)

The corpsman/technician will give artificial respiration by the most appropriate available method--mouth to mouth, mouth to airway, modified Silvester, Holger Nielson, Ambu bag, respirator, and other standard resuscitation equipment--insert an airway; reassure and calm a conscious or semiconscious victim and his family, if present; inform medical personnel directly or indirectly of the individual's symptoms, needs, and treatment as soon as possible; and record on proper hospital or emergency records the treatment given, the individual's response, and the notification of medical personnel.

Performance Objective (Conditions)

Without supervision and with an assistant or technical assistant as needed and available.

Performance Objective (Criteria)

According to established standard procedures, techniques, and routines for administering artificial respiration by the method used in the treatment.

Performance Objective (Consequence)

Either individual's respirations will be restored or death, dependent to a great extent upon the speed and correctness of applying artificial respirations.

Performance Objective (Next Action)

Refer the patient to physician for additional care.

Knowledge and Skills

1. Anatomy and physiology of respiratory tract
2. Removal of respiratory obstructions and free victim of mechanical interferences
3. Observation techniques for assuring removal of obstruction and effectiveness of artificial respirations.
4. Communication techniques for encouraging and instructing conscious or semiconscious victim and directing assistants.

5. Moving and positioning of patient for treatment
6. Methods, contraindications, precautions of artificial respiration by mouth to mouth, mouth to airway, modified Silvester, Holger Nielsen, Ambu bag, respirator, and other standard resuscitation equipment.
7. Procedure and techniques for inserting airway and for administering artificial respiration to victim with tracheotomy or laryngectomy.
8. Routine for reporting to medical personnel in hospital and non-hospital environment victim's treatment, response, and needs.
9. Routine for recording victim's treatment, condition, and response to treatment in hospital and non-hospital environment.

Instructional Strategies

1. Pretest and/or review on anatomy and physiology of respiratory tract; signs and symptoms of respiratory obstruction; procedures and techniques for removing various types of respiratory obstructions and freeing victim from mechanical interferences; observation and communication skills relative to treatment; routines for reporting to medical personnel and recording on appropriate records.
2. Slides, filmstrips, films, videotapes, and/or mediated programmed instruction (individual or group) on purpose, procedures, techniques, and routines for inserting airway and for administering artificial respiration by mouth to mouth, mouth to airway, modified Silvester, Holger Nielsen, Ambu bag, respirator, and by other standard resuscitation equipment and through tracheotomy tube in case of tracheotomy or laryngectomy. Contraindications and precautions relative to each procedure.
3. Hardcover programmed instruction
4. Lecture
5. Discussion
6. Demonstration
7. Practice in simulated patient care unit
8. Study assignments
9. Written exercises

Training Aids

1. Filmstrips/films/videotapes
2. Mediated programmed instruction
3. Hardcover programmed instruction
4. Slides

5. Chalk board
6. Wall chart
7. Anatomical models
8. Equipment and supplies
9. Instructor's guide
10. Student syllabus
11. References

Examination Modes

1. Response in classroom
2. Paper and pencil test
3. Rating on performance in simulated practice
4. Rating on performance in work situation (feedback)
5. Oral quiz on knowledge related to performance in simulated practice and/or work situation (feedback)

Training Time

- 1:00 hour didactic
- 2:00 hours supervised practice

LEARNING MODULE IM9
APPLICATION OF BINDERS, BANDAGES, AND STRAPPING

Tasks

- 320328 Cross check medication and treatment card with KARDEX and doctor's orders
- 110063 Verify identification of patient, e.g., for treatment, medication, examination
- 120080 Inform patient of procedure prior to/during examination/test/treatment
- 150078 Ask patient/check chart for contraindication for treatment/procedure/test
- 120046 Reassure/calm apprehensive/anxious patient
- 120088 Reassure/calm children for examination/treatment
- 120085 Reassure apprehensive parents of pediatric patient
- _____ Wash hands prior to/after patient care, medication, treatment, examination, procedure, specimen collecting and handling
- 110103 Apply binders, e.g., T, scultetus, breast
- 140407 Wrap stump for shape/shrinkage
- 140265 Apply/change bandage, e.g., roller, triangle, Kurlex
- 140023 Apply elastic bandage
- 140027 Apply/remove sling, e.g., arm, leg
- 140037 Patch eyes
- 130436 Evaluate patient's complaints/symptoms of pain
- 130382 Observe/record patient's physical/emotional response to treatment/diagnostic procedure
- 150036 Inform doctor/nurse of patient's condition, e.g., description of symptoms, injuries, or response
- 230162 Wash glassware and instruments
- 230251 Disinfect instruments/materials/equipment
- 150064 Write nursing notes
- _____ Record on nursing care plan

Performance Objective (Stimulus)

When assigned by the senior corpsman/technician, nurse, or doctor to apply binders, bandages, and/or strapping as ordered by the physician or when patients in emergency situations require binders, bandages, and/or strapping.

Performance Objective (Behavior)

The corpsman/technician will verify the doctor's orders if in the hospital; verify the patient's identity; communicate with the patient about the procedure and any contraindications for it; reassure the apprehensive patient and/or his family; apply the type of bandage or binder ordered or indicated; observe the patient's response and report to supervisory personnel and record on the appropriate hospital and emergency care records.

Performance Objective (Conditions)

Without supervision or with indirect supervision and with or without assistance, depending on the patient's condition.

Performance Objective (Criteria)

In accordance with established standard procedures for application of binders, bandages, and strapping and in emergency situations dependent upon available resources.

Performance Objective (Consequence)

Patient will be correctly bandaged using the proper bandage or binder.

Performance Objective (Next Action)

Check patient's condition and condition of bandages or binders.

Knowledge and Skills

1. Types and functions of binders, bandages, and strapping in care of surgical wounds and other patient conditions, and in emergency treatment and first aid.
2. Anatomy and physiology of body parts to be bandaged, bound, and/or strapped
3. Communication techniques to give information to and elicit it from the patient and to report to supervisory personnel
4. Observation techniques for assessing the patient's condition and response to procedure
5. Routine for verification of doctor's orders if hospital patient and verification of patient's identity.

6. Patient's diagnosis, therapy, and condition relative to application of required binder, bandage, and/or strapping.
7. Criteria for determining contraindications for applying binders, bandages, and/or strapping.
8. Procedure and techniques for applying binders, such as T, scultetus, breast; roller bandage to fingers, toes, feet, hands, limbs, and head; triangular bandages to head, hands, feet, chest, and as arm and leg slings; cravat bandage to jaws and face, head, ribs, and use as tourniquet; elastic bandage and adhesive tape strappings; and eye patches.
9. Precautionary measures in the use of all binders, bandages, strapping, and tourniquets.
10. Routine for recording application of binders, bandages, and strapping on nursing notes and patient care plan or patient's emergency record.
11. Routine for suggesting changes in patient care and modifying nursing care plan accordingly.

Instructional Strategies

1. Pretest and/or review on communication and observation skills; anatomy and physiology of body parts as related to application of binders, bandages, and strapping; routines for verifying doctor's orders and patient's identity; routines for recording and reporting.
2. Slides, filmstrips, films, videotapes, and/or mediated programmed instruction (individual or group) on types and functions of binders, bandages, and strapping; procedures and techniques for applying binders, bandages, and strapping; contraindication and precautionary measures in their application and use.
3. Hardcover programmed instruction
4. Lecture
5. Discussion
6. Demonstration
7. Practice in simulated patient care unit
8. Practice in work situation
9. Study assignments
10. Written exercises

Training Aids

1. Filmstrips/films/videotapes
2. Mediated programmed instruction

3. Hardcover programmed instruction
4. Slides
5. Chalk board
6. Wall charts
7. Anatomical models
8. Equipment and supplies
9. Instructor's guide
10. Student syllabus
11. References

Examination Modes

1. Response in classroom
2. Paper and pencil test
3. Rating on performance in simulated practice
4. Rating on performance in work situation (feedback)
5. Oral quiz on knowledge related to performance in simulated practice and/or work situation (feedback)

Training Time

- 2:00 hours didactic
- 4:00 hours supervised practice

LEARNING MODULE IM10
HEMORRHAGE: EXAMINATION OF

Tasks

- 150143 Initiate treatment procedure in the absence of a doctor
- 130081 Obtain preliminary medical history, e.g., past/present complaints, allergies, medications
- 130271 Observe for symptoms of internal hemorrhage
- 130270 Observe for symptoms of external hemorrhage
- 130264 Observe for/report or describe symptoms of irritability, restlessness, apprehension
- 130374 Observe patient's general emotional condition, e.g., facial and eye expressions, quality of voice
- 130404 Check/count respirations
- 130099 Observe patient for/report and describe abnormal respirations
- 130110 Perform circulation check, e.g., color, pulse, temperature of skin, capillary return
- 130016 Check radial (wrist) pulse
- 130010 Check femoral pulse
- 130011 Check pedal pulse
- 130407 Check color of skin, e.g., cyanosis, blanching, jaundice, mottling
- 130410 Check for sweating/diaphoresis
- 130100 Observe patient for signs of chilling
- 130409 Check temperature of skin
- 130014 Check patient's temperature
- 130006 Check blood pressure
- 130015 Check pupil reaction to light
- 130260 Observe and report symptoms of dehydration
- 130073 Estimate/record blood loss following hemorrhage
- 130007 Check dressings, e.g., cleanliness
- 130388 Observe/record or describe characteristics of urine, feces, or vomitus, or regurgitation
- 130425 Observe/record or describe characteristics of sputum, mucus
- 130244 Palpate (feel) abdomen for distention (hardness, softness)

- 120046 Reassure/calm apprehensive/anxious patient
- 120088 Reassure/calm children for examination or treatment
- 120085 Reassure apprehensive parents of pediatric patient
- 150036 Inform doctor/nurse of patient's condition, e.g., description of symptoms, injury or response
- 150073 Notify medical personnel of treatment needs of patient
- 150064 Write nursing notes
- 150208 Make entry on SF600 "Chronological Record of Medical Care"

Performance Objective (Stimulus)

When a patient or victim with an open wound or possible internal injuries becomes restless and apprehensive and in the absence of a physician, nurse, or senior corpsman/technician.

Performance Objective (Behavior)

The corpsman/technician will examine for signs and symptoms of hemorrhage which include amount of bleeding; condition of the skin, vital signs, hydration status, reaction of pupils, behavior response, and in the case of possible internal hemorrhage, output from the gastrointestinal, urinary, and respiratory tracts and the condition of the abdomen. He will elicit needed information from the patient or victim and/or family and reassure them; report to medical personnel his examination findings and record on appropriate hospital or non-hospital records.

Performance Objective (Conditions)

Without supervision or assistance.

Performance Objective (Criteria)

According to established standard procedures, techniques, and routines.

Performance Objective (Consequence)

An accurate evaluation of the patient's bleeding.

Performance Objective (Next Action)

If indicated, treat for hemorrhage; otherwise make the patient as comfortable as possible.

Knowledge and Skills

1. Purpose of examination for hemorrhage
2. Anatomy and physiology of the circulatory system
3. Signs and symptoms that indicate external hemorrhage: restlessness, thirst; faintness; dizziness; cold, clammy skin; dilated pupils; shallow or irregular breathing at increased rate; thin, rapid, weak and irregular pulse beat; a vague feeling of great anxiety; and an excessive amount of bleeding.
4. Signs and symptoms that indicate internal hemorrhage: same as for external, plus possible presence of blood in respiratory, urinary, and/or gastrointestinal outputs and common signs of acute abdominal illness.
5. Communication techniques for eliciting information from the patient, victim, and/or family and for giving information and encouragement to them.
6. Observation techniques for assessing status of hemorrhage and patient's or victim's condition.
7. Routine for reporting to medical personnel in a hospital or non-hospital environment.
8. Routine for recording examination findings on patient's hospital record or victim's emergency record.

Instructional Strategies

1. Pretest and/or review on anatomy and physiology of the circulatory system and blood; pulse and respiration abnormalities; normal and abnormal skin color; symptoms of apprehension and anxiety; communication and observation skills; reporting and recording routines.
2. Slides, filmstrips, films, videotapes, and/or mediated programmed instruction (individual or group) on history, signs and symptoms of external and internal hemorrhage, and extent of hemorrhage.
3. Hardcover programmed instruction
4. Lecture
5. Discussion
6. Demonstration

7. Practice in simulated patient care unit
8. Study assignments
9. Written exercises
10. Case studies

Training Aids

1. Filmstrips/films/videotapes
2. Mediated programmed instruction
3. Hardcover programmed instruction
4. Slides
5. Chalk board
6. Wall charts
7. Instructor's guide
8. Student syllabus
9. References

Examination Modes

1. Response in classroom
2. Paper and pencil test
3. Rating on performance in simulated practice
4. Rating on performance in work situation (feedback)
5. Oral quiz on knowledge related to performance in simulated practice and/or work situation (feedback)
6. Case studies

Training Time

0:30 hour didactic

0:30 hour supervised practice in conjunction with Learning Module IM11,
"Hemorrhage: Emergency Treatment for"

LEARNING MODULE IM11
HEMORRHAGE: EMERGENCY TREATMENT FOR

Tasks

- 150143 Initiate procedure in the absence of a doctor
- 140044 Give emergency treatment/first aid for external bleeding
- 140391 Control bleeding by applying digital pressure on blood vessel
- 140020 Apply/change sterile dressings
- 140059 Control minor bleeding, e.g., after extraction or incision
- 140128 Pack incision/wound/cavity
- 140060 Control bleeding by pressure dressings
- 140285 Reinforce dressings, i.e., add dressings
- 140058 Control bleeding by applying tourniquets
- 110124 Position extremities to relieve swelling or bleeding
- 140031 Apply wet compresses, soaks, packs
- 140275 Force fluid intake
- 140389 Administer narcotics
- 140086 Give oxygen therapy, i.e., cannula, catheter/mask
- _____ Apply ice bag
- 130073 Estimate/record blood loss following hemorrhage
- 140192 Administer blood expanders other than blood, e.g., plasma, albumin
- 130436 Evaluate patient's complaints/symptoms of pain
- 120046 Reassure/calm apprehensive/anxious patient
- 120088 Reassure/calm children for examination or treatment
- 120085 Reassure/calm apprehensive parents of pediatric patient
- 150036 Inform doctor/nurse of patient's condition, e.g., description of symptoms, injury or response
- 150073 Notify medical personnel of treatment needs of patient
- 150064 Write nursing notes
- 150208 Make entry on SF600 "Chronological Record of Medical Care"

Performance Objective (Stimulus)

When a patient or victim has been examined, found to be hemorrhaging, a physician, nurse, or senior corpsman/technician is not present, and medical assistance is being awaited.

Performance Objective (Behavior)

The corpsman/technician will control bleeding by pressure dressings, use of pressure points, use of tourniquets; give supportive treatment including positioning, maintenance of body temperature, elevation of bleeding extremity, provision of fresh circulating air or oxygen, application of heat and cold, encouragement of fluid intake, and reassurance for apprehension and anxiety; replace body fluids; give drugs for pain; observe the patient's or victim's condition and his response to treatment; communicate with the patient or victim or his family or friends about his condition, and reassure him and them; report to medical personnel the condition and patient's or victim's response to treatment; and record on appropriate records the treatment, patient's or victim's response to treatment and his condition.

Performance Objective (Conditions)

Without supervision and with or without assistance, depending upon need and availability of assistance.

Performance Objective (Criteria)

In accordance with established standard procedures, techniques, and routines.

Performance Objective (Consequence)

Patient or victim receives emergency treatment for hemorrhage.

Performance Objective (Next Action)

Refer the patient or victim to the physician for further treatment.

Knowledge and Skills

1. Purpose of hemorrhage control
2. Anatomy and physiology of wound area as related to blood vessels, tissue, and organs
3. Anatomy and physiology of gastrointestinal, urinary, and respiratory tracts as related to bleeding or hemorrhaging.
4. Anatomy and physiology of the abdominal cavity, organs, and tissues as related to internal bleeding.

5. Kinds of bleeding: arterial, venous, and capillary and significance of control
6. Physiology of blood clotting as related to hemorrhage control
7. Treatment of external hemorrhage by exerting pressure on pressure points for control--extremities, head, neck, face, scalp, armpit, and chest wall; by applying pressure dressings, and by applying tourniquets. Precautions for each control method.
8. Supportive treatment--reclining position with head slightly raised except in shock, elevation of bleeding extremity; warm but not overheated; reassurance for apprehension; fresh circulating air or oxygen; encourage non-stimulant fluids except in case of gastrointestinal injury, then omit them; use of sterile hot compresses and ice bag for capillary bleeding.
9. Communication techniques for eliciting information from the patient, victim, and family or friends and encouragement to them.
10. Observation techniques for assessing effectiveness of hemorrhage control and patient's or victim's general condition.
11. Routine for reporting patient's or victim's condition and response to treatment to medical personnel in a hospital or non-hospital environment.
12. Routine for recording hemorrhage treatment, extent of control, and patient's or victim's condition on hospital or emergency records.

Instructional Strategies

1. Pretest and/or review on anatomy and physiology of blood vessels, body tissues, organs, and systems as related to hemorrhage; physiology of blood clotting in hemorrhage control; application of tourniquets and bandages; communication and observation skills; and reporting and recording routines.
2. Slides, filmstrips, films, videotapes, and/or mediated programmed instruction (individual or group) on procedures, techniques, and routines for hemorrhage control by use of pressure points, pressure dressings, and tourniquets and precautions for use; supportive treatment for hemorrhage and its significance.
3. Hardcover programmed instruction
4. Lecture
5. Discussion
6. Demonstration
7. Practice in simulated patient care unit
8. Study assignments
9. Written exercises
10. Case studies

Training Aids

1. Filmstrips/films/videotapes
2. Mediated programmed instruction
3. Hardcover programmed instruction
4. Slides
5. Wall charts
6. Chalk board
7. Anatomical models
8. Equipment and supplies
9. Instructor's guide
10. Student syllabus
11. References

Examination Modes

1. Response in classroom
2. Paper and pencil test
3. Rating on performance in simulated practice
4. Rating on performance in work situation (feedback)
5. Oral quiz on knowledge related to performance in simulated practice and/or work situation (feedback)
6. Case studies

Training Time

1:30 hours didactic

1:00 hour supervised practice in conjunction with Learning Module IM10,
"Hemorrhage: Examination of"

LEARNING MODULE 1M12
SHOCK: EXAMINATION FOR

Tasks

- 150143 Initiate procedure in the absence of a doctor
- 130081 Obtain preliminary medical history, e.g., past/present complaints, allergies, medications
- 130059 Observe for and report symptoms of shock
- 130389 Observe for/report patient's level of physical activity, e.g., lethargy, hyperactivity
- 130264 Observe for symptoms of irritability, restlessness, apprehension
- 130411 Check patient's response to painful stimuli
- 130393 Observe and report patient's level of consciousness
- 130407 Check color of skin, e.g., cyanosis, blanching, jaundice, mottling
- 130409 Check temperature of skin
- 130100 Observe patient for signs of chilling
- 130410 Check for sweating/diaphoresis
- 130014 Check patient's temperature
- 130016 Check radial (wrist) pulse
- 130011 Check pedal pulse
- 130010 Check femoral pulse
- 130110 Perform circulation check, e.g., color, pulse, temperature of skin, capillary return
- 130404 Check/count respirations
- 130099 Observe patient for and describe abnormal respirations
- 130006 Check blood pressure
- 130015 Check pupil reaction to light
- 130112 Perform neurological (cranial) check: pupils, vital signs, patient's response
- 130436 Evaluate patient's complaints or symptoms of pain
- 130271 Observe for symptoms of external hemorrhage
- 130270 Observe for symptoms of internal hemorrhage
- 120046 Reassure/calm apprehensive/anxious patient
- 150036 Inform doctor/nurse of patient's condition, e.g., description of symptoms, injury, or response

150075 Notify medical personnel of needs of patient
150064 Write nursing notes
150208 Make entry on SF600 "Chronological Record of Medical Care"

Performance Objective (Stimulus)

When an individual has been injured, is ill, has received certain medications, and begins to show signs of mental sluggishness and weakness or faintness and a physician, nurse, or senior corpsman/technician is not present.

Performance Objective (Behavior)

The corpsman/technician will examine the patient or victim for shock by observing the extent of sluggishness, weakness, faintness; the color of the face; the temperature and condition of the skin; the rate, kind and rhythm of the respirations and pulse; the eye and pupil response; the extent of restlessness and/or apprehension; the extent of injury and/or hemorrhage; nausea with or without vomiting; and the level of consciousness. He will take the blood pressure; reassure the apprehensive or anxious patient; notify medical personnel for immediate assistance and record on the patient's chart or victim's record his findings and the condition of the patient.

Performance Objective (Conditions)

Without supervision and with or without assistance, depending on the patient's or victim's condition and the availability of assistance.

Performance Objective (Criteria)

In accordance with established standard procedures, techniques, and routines for identifying the signs and symptoms of shock.

Performance Objective (Consequence)

Assessment of the patient or victim with impending shock.

Performance Objective (Next Action)

Treat shock symptoms and obtain medical aid as soon as possible.

Knowledge and Skills

1. Purpose of the examination
2. Causes of shock; severe injury or illness and reaction of body to overwhelming sensitization by foreign protein, e.g., foods, medicine, sting.
3. Physiology of the body as related to shock and shock symptoms
4. Symptoms of shock: weakness, faintness, mental sluggishness, collapse; face pale, skin cold and moist (clammy); eyelids drooping, eyes vacant and dull, pupils dilated; breathing rapid, shallow, irregular or deep; pulse weak, irregular, fast or too weak to feel; blood pressure below 100/60; nausea with or without vomiting; thirst and restlessness and unconsciousness.
5. Significance of shock as related to patient or victim's condition
6. Communication techniques for eliciting information from patient or victim, family and friends, giving information and encouragement to them, and directing assistants.
7. Observation techniques for assessing patient's or victim's condition
8. Routine for notifying medical personnel of patient's condition and need for assistance.
9. Routine for recording examination findings on appropriate records

Instructional Strategies

1. Pretest and/or review on normal and abnormal vital signs; skin color, temperature and feeling to touch; appearance of eyes and pupil reaction; levels of consciousness; observation and communication skills; routines for reporting to medical personnel and recording on patient's or victim's record.
2. Slides, filmstrips, films, videotapes, and/or mediated programmed instruction (individual or group) on procedures, techniques, and routines for assessing patient's or victim's shock symptoms.
3. Hardcover programmed instruction
4. Lecture
5. Discussion
6. Demonstration
7. Practice in simulated patient care unit
8. Study assignments
9. Written exercises

Training Aids

1. Filmstrips/films/videotapes
2. Mediated programmed instruction
3. Hardcover programmed instruction
4. Slides
5. Chalk board
6. Wall charts
7. Equipment and supplies
8. Instructor's guide
9. Student syllabus
10. References

Examination Modes

1. Response in classroom
2. Paper and pencil test
3. Rating on performance in simulated practice
4. Rating on performance in work situation (feedback)
5. Oral quiz on knowledge related to performance in simulated practice and/or work situation (feedback)

Training Time

0:30 hour didactic

0:30 hour supervised practice in conjunction with Learning Module IM13,
"Shock: Emergency Treatment for"

LEARNING MODULE IM13
SHOCK: EMERGENCY TREATMENT FOR

Tasks

- 150143 Initiate treatment procedure in the absence of a doctor
- 110116 Position patient who has symptoms of shock
- 140047 Give emergency treatment or first aid for shock
- 140508 Give emergency treatment or first aid for syncope (fainting)
- 140462 Give emergency treatment or first aid for anaphylactic shock
- 140044 Give emergency treatment or first aid for external hemorrhage
- 140391 Control bleeding by applying digital pressure on blood vessel
- 140058 Control bleeding by applying tourniquets
- 140060 Control bleeding by applying pressure dressings
- 140285 Reinforce dressings, i.e., add dressings
- 140039 Give emergency treatment/first aid for respiratory impairment
- 140275 Force fluid intake
- 140389 Administer narcotics
- _____ Keep the victim quiet, warm and as comfortable as possible
- _____ Loosen tight clothing, e.g., collar, waistband, belt
- 120046 Reassure/calm apprehensive/anxious patient
- 120088 Reassure/calm children for examination/treatment
- 120085 Reassure/calm apprehensive parents of pediatric patient
- 130436 Evaluate patient's complaints/symptoms of pain
- 150036 Notify doctor/nurse of patient's condition, e.g., description of symptoms, injury, response
- 150073 Notify medical personnel of needs of patient
- 150064 Write nursing notes
- 150208 Make entry on SF600 "Chronological Record of Medical Care"

Performance Objective (Stimulus)

When a patient or victim has been examined and shock is imminent or present; a physician, nurse, or senior corpsman/technician is not present; and medical assistance is being awaited.

Performance Objective (Behavior)

The corpsman/technician will lay the patient or victim down with lower extremities and/or body elevated unless contraindicated by type of injury; keep him warm avoiding use of excessive heat, especially in hemorrhage cases; relieve any respiratory impairment and prevent aspiration of vomitus or mucus; splint fractures; encourage fluids if patient is conscious; administer drugs for relief of pain; reassure patient or victim (if conscious), family, and friends; notify medical personnel of patient's or victim's condition, treatment, and response to treatment and record same on appropriate records.

Performance Objective (Conditions)

Without supervision and with or without assistance, depending on patient's or victim's condition and availability of assistants.

Performance Objective (Criteria)

In accordance with established standard procedures, techniques, and routines.

Performance Objective (Consequence)

Emergency treatment for shock being given to patient or victim.

Performance Objective (Next Action)

Transfer the patient or victim to the physician for treatment.

Knowledge and Skills

1. General treatment for shock: keep patient lying down, conserve body heat, and give him fluids; place patient in reclining position with lower extremities and/or body higher than head, except in chest and head injuries--for chest injuries, raise only the head and shoulders, and in head injuries, keep patient flat; control hemorrhage; relieve pain by splinting injury; use drugs for pain as last resort--never give morphine for skull fracture and/or head injury.

SYNCOPE:

Causes--stagnation of blood in lower extremities and decreased oxygen to the brain.

Treatment--place in flat position with lower extremities elevated.

ELECTRIC SHOCK:

Causes--electrical current or lightening.

Indications--unconsciousness; absence of breathing; a weak pulse or none at all; body burns at point of current entrance and exit.

Rescue procedures--shut off current; move victim from current contact without direct contact with victim; use non-conducting material to move victim.

Treatment--break contact; call doctor or ambulance; give artificial respirations; when breathing, keep warm, quiet, in semi-recumbent position, administer oxygen as required; control post-shock/hyperactivity.

ANAPHYLACTIC SHOCK:

Causes--reaction of body to overwhelming sensitization by a foreign protein.

Indications--swelling of vocal cords; restlessness; mottled, livid, blue skin; severe coughing; difficult breathing; severe headache; rapid onset of unconsciousness; and may be swelling of abdomen with severe pain, nausea, vomiting, and diarrhea.

Treatment--keep warm, comfortable in semi-reclining position; give 0.5 ml. Ephedrine 1:1000 subcutaneously and repeat every 10 minutes if no response; in case of sting to extremity, apply tourniquet above, scrape out sting; in case of laryngeal obstruction, give Epinephrine and as last resort do tracheotomy.

2. Communication techniques for eliciting information from the patient or victim, family, and friends; for giving information and encouragement to them; and for directing assistants.
3. Observation techniques for assessing presence of shock or impending shock, patient's or victim's condition, and response to treatment.
4. Routine for notifying medical personnel for assistance in hospital and non-hospital environment.
5. Routine for recording patient's or victim's condition, treatment, and response to treatment on appropriate records.

Instructional Strategies

1. Pretest and/or review on moving and positioning patient; control of hemorrhage; cause of wounds; relief of respiratory obstruction; application of heat; encouraging intake of fluids; administration of medications; communication and observation skills; reporting and recording routines.
2. Slides, filmstrips, films, videotapes, and/or mediated programmed instruction (individual or group) on procedures, techniques, and routines applicable to treatment for fainting, electric shock, and anaphylactic shock. Causes and special treatment for electric and anaphylactic shock.

AD-A085 706

TECHNOMICS INC OAKTON VA

A SYSTEM APPROACH TO NAVY MEDICAL EDUCATION AND TRAINING. APPEN--ETC(11)

F/G S/G

AUG 76

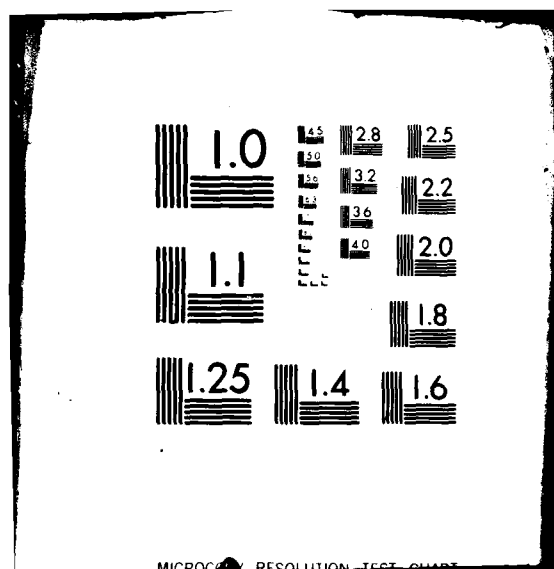
N00014-69-C-0246

NL

UNCLASSIFIED

5 of 7

AD-A085 706



3. Hardcover programmed instruction
4. Lecture
5. Discussion
6. Demonstration
7. Practice in simulated patient care unit
8. Study assignments
9. Written exercises
10. Case studies

Training Aids

1. Filmstrips/films/videotapes
2. Mediated programmed instruction
3. Hardcover programmed instruction
4. Slides
5. Chalk board
6. Anatomical models
7. Equipment and supplies
8. Instructor's guide
9. Student syllabus
10. References

Examination Modes

1. Response in classroom
2. Paper and pencil test
3. Rating on performance in simulated practice
4. Rating on performance in work situation (feedback)
5. Oral quiz on knowledge related to performance in simulated practice and/or work situation (feedback)
6. Case studies

Training Time

0:30 hour didactic

0:30 hour supervised practice

LEARNING MODULE IM14
WOUNDS: EMERGENCY TREATMENT FOR

Tasks

- 150143 Initiate procedure in the absence of a doctor
- 130081 Obtain preliminary medical history, e.g., past/present complaints, allergies, medications
- 150054 Clean wound, cut, abrasion
- 130060 Examine for entry and exit area of shrapnel or bullets
- 140508 Give emergency treatment/first aid for lacerations
- 140451 Give emergency treatment/first aid for eviscerations
- _____ Give emergency treatment/first aid for wringer injuries of upper extremities
- 140505 Give emergency treatment/first aid for blast injuries
- _____ Give emergency treatment/first aid for crush injuries
- 140505 Give emergency treatment/first aid for gunshot wounds
- 140444 Give emergency treatment/first aid for hemo-, pneumothorax
- 140287 Dress or pack sucking chest wound
- 140020 Apply/change sterile dressings
- 140128 Pack incision/wound/cavity
- 140441 Apply battle dressings
- 140439 Apply/change head and neck dressings
- 140437 Apply/change abdominal dressings
- 140099 Apply/change dressings to an open amputated stump
- 110103 Apply binders, e.g., T, scultetus, breast
- 140265 Apply/change bandages, e.g., roller, triangle, Kurlex
- 140023 Apply elastic bandage
- 140285 Reinforce dressings, i.e., add dressings
- 140389 Administer narcotics
- 120046 Reassure/calm apprehensive/anxious patient
- 120088 Reassure/calm children for examination or treatment
- 120085 Reassure/calm apprehensive parents of pediatric patient
- 150036 Inform doctor/nurse of patient's condition, e.g., description of symptoms, injury or response

- 150073 Notify medical personnel of treatment needs of patient
- 150064 Write nursing notes
- 150208 Make entry on SF600 "Chronological Record of Medical Care"

Performance Objective (Stimulus)

When a patient or victim has been examined who has been wounded; a physician, nurse, or senior corpsman/technician is not present; and medical assistance is being awaited.

Performance Objective (Behavior)

The corpsman/technician will assess the kind of wound--contusion, abrasion, lacerated; incised, puncture, crush, wringer, blast; simple single wound or complicated by other external and internal injuries; clean and dress the wound as indicated; administer medication for pain and/or tetanus; treat for impending shock or shock; control bleeding; elicit information about the wound and reassure the patient or victim, the family, and friends; inform medical personnel of the patient's or victim's condition, treatment, and response to treatment; and record patient's condition, treatment, and response on appropriate records.

Performance Objective (Conditions)

Without supervision and with or without assistance, depending on the patient's or victim's condition and the availability of help.

Performance Objective (Criteria)

In accordance with established standard procedures, techniques, and routines.

Performance Objective (Consequence)

Emergency treatment of patient or victim with wound.

Performance Objective (Next Action)

Refer patient or victim to medical personnel for further treatment.

Knowledge and Skills

1. Purpose of emergency treatment of wounds
2. Type of wound, treatment, and precautions:

Simple contusions or bruises--treat with cold compresses for 24 hours followed by heat and rest.

Abrasions or scrapes and irregular superficial wounds of skin--remove foreign matter; clean with hydrogen peroxide; apply dry, non-sticky dressing.

Lacerations (jagged, ragged tearing of tissues)--for small ones, clean; apply butterfly strip, cover with clean, dry, non-sticky dressing; for major lacerations (from such as car accidents), apply dressing and control hemorrhage and transfer to medical care.

Incised (cut), as from broken glass--clean; draw edges together with butterfly strip, and apply dressing; if major, cover with dressing, treat hemorrhage, and transfer for medical care.

Puncture (puncture of skin or skin and tissue with sharp instrument such as nail, splinter, bites, stings, and gunshot)--apply dry, non-sticky dressing; give routine emergency treatment for stings, nail punctures, gunshot wounds, and bites; clean wound; apply dry, non-sticky dressing; and transfer to medical care. Caution of lockjaw for nails, rabies, for bites, hemo-, pneumothorax, and for gunshot wounds of chest.

Crush injury caused by falling debris or automobile accident--put in shock position; treat pain; keep comfortably warm (no heat); supply fluids; and refer to medical care.

Wringer victim (upper extremity caught in equipment)--clean hand and arm; apply sterile dressings; wrap in compression dressing covered with elastic bandage; suspend arm above body to decrease blood flow and prevent further swelling; and refer to medical care.

Blast injury caused by explosion--treat external wounds and/or internal injury--must be hospitalized for several days' observations, although no apparent injury.

Sucking wound of chest with pneumothorax or hemopneumothorax--serious wounds rate high priority for evacuation in mass disaster; apply petrolatum impregnated gauze followed by large thick compression dressing firmly attached with bandage.

3. Administration of narcotics or other drug for pain, tetanus antiserum, or tetanus toxoid, or medication for lockjaw prevention.
4. Hemorrhage control as indicated by kind and extent of wound
5. Shock treatment as required by patient or victim

6. Communication techniques for eliciting information from patient, victim, family and friends, giving information and reassurance to them, and directing assistants.
7. Observation techniques for assessing patient's or victim's condition and response to treatment.
8. Routine for notifying medical personnel for assistance in hospital and non-hospital environment.
9. Routine for recording patient's or victim's condition, treatment, and response to treatment on appropriate records.

Instructional Strategies

1. Pretest and/or review on anatomy and physiology of skin and underlying tissues and blood; administration of medications; hemorrhage control; shock treatment; communication and observation techniques; routines for notifying medical personnel; and routines for recording patient's or victim's condition, treatment, and response to treatment.
2. Slides, filmstrips, films, videotapes, and/or mediated programmed instruction (individual or group) on procedures, techniques, and routines for treating various types of wounds; purpose for each type of treatment; and precautions relating to treatment.
3. Hardcover programmed instruction
4. Lecture
5. Discussion
6. Demonstration
7. Practice in simulated patient care unit
8. Study assignments
9. Written exercises
10. Case studies

Training Aids

1. Filmstrips/films/videotapes
2. Mediated programmed instruction
3. Hardcover programmed instruction
4. Slides
5. Chalk board
6. Wall charts
7. Anatomical models

8. Equipment and supplies
9. Instructor's guide
10. Student syllabus
11. References

Examination Modes

1. Response in classroom
2. Paper and pencil test
3. Rating on performance in simulated practice
4. Rating on performance in work situation (feedback)
5. Oral quiz on knowledge related to performance in simulated practice and/or work situation (feedback)
6. Case studies

Training Time

1:00 hour didactic

1:30 hours supervised practice

LEARNING MODULE IM15
WOUNDS: EMERGENCY SUTURING OF

Tasks

- 150137 Ensure that doctor's orders are carried out
- 110063 Verify identification of patient, e.g., for treatment, medications, examination
- 120080 Inform patient of procedure prior to/during examination/test/treatment
- 120010 Explain/answer patient's questions regarding examination/test/treatment/procedure
- 120090 Explain minor surgical procedure/operation to patient/family
- 150141 Elicit information to ascertain patient's understanding of illness/treatment
- 320327 Witness/ensure patient's consent/permission has been obtained for treatment/examination/release
- 130436 Evaluate patient's complaints/symptoms of pain
- 120046 Reassure/calm apprehensive/anxious patient
- 145041 Arrange furniture/set up equipment/supplies for procedure, e.g., examination/treatment
- 110005 Assist patient in/out of bed, examination or OR table
- 110081 Position/hold patient for examination, treatment, surgery
- 230207 Select/set up instruments for minor surgical procedures
- 145042 Label medicine glasses with name and amount of drug for sterile field
- 145021 Adjust surgical spot light
- 200003 Check instruments and supplies for sterilization indicator
- 110044 Shave/scrub patient for surgery, treatment, or examination
- 110025 Give phisoex/butadine scrub to patient
- 110043 Prepare skin site with antiseptic solution prior to medical examination/treatment
- 145001 Perform hand scrubbing technique prior to surgical/sterile procedure
- 145044 Glove for the sterile procedure
- 110013 Drape/gown patient for examination/procedure
- 140243 Apply topical anesthesia
- 140432 Administer tissue infiltration/local anesthesia
- 140177 Suture skin

- 140178 Suture subcutaneous tissue
_____ Cut sutures at surgical site
- 140020 Apply/change sterile dressings
- 130382 Observe/record patient's physical/emotional response to treatment/
diagnostic procedure
- 110010 Clean and clothe patient after surgery, treatment, examination
- 150036 Inform doctor/nurse of patient's condition, e.g., description of
symptoms, injuries or response
- 150073 Notify medical personnel of treatment needs of patient
- 150208 Make entry on SF600 "Chronological Record of Medical Care"
- 230162 Wash glassware and instruments
- 230251 Disinfect instruments/material/equipment

Performance Objective (Stimulus)

When patient in emergency room has a superficial wound that cannot be approximated with butterfly strapping and when ordered by the doctor to suture the wound.

Performance Objective (Behavior)

The corpsman/technician will verify the identification of the patient; inform him about the suturing procedure, obtain his written permission, answer his questions, and reassure him; obtain the necessary surgical set-up and arrange it on the suturing table; assist the patient onto the examination table and position him; shave, scrub, and prepare skin site with antiseptic solution; perform surgical hand scrub and put on surgical gloves; drape the wound site; give local anesthesia as ordered; suture the wound and apply sterile dressings; clean and clothe the patient; evaluate the patient's response to suturing and notify medical personnel; transfer patient to admission or release with instructions on care and return to clinic according to patient's condition and doctor's orders; make written entry on appropriate records about suturing and patient's condition; and clean up and take care of used equipment.

Performance Objective (Conditions)

With indirect supervision and with or without an assistant, depending upon the condition of the patient.

Performance Objective (Criteria)

In accordance with established standard procedures, techniques, and routines.

Performance Objective (Consequence)

Patient's superficial wound will be sutured and dressed.

Performance Objective (Next Action)

Continue with next assignment.

Knowledge and Skills

1. Purpose of suturing superficial wounds
2. Anatomy and physiology of skin and underlying tissues, and blood as related to hemorrhage.
3. Communication techniques for giving information to and eliciting information from the patient and for reporting to supervisory personnel
4. Observation techniques for assessing the patient's condition and response to the suturing procedure.
5. Routine for verification of doctor's orders and patient's identity
6. Patient's diagnosis, therapy, and condition as related to the suturing process
7. Procedures, techniques, and routines for setting up for suturing and suturing of superficial wounds and recording on appropriate emergency room records.
8. Precautionary measures relative to sterile techniques and permission to perform suturing procedure, especially on minors.
9. Routines and procedures for clean up and care of equipment

Instructional Strategies

1. Pretest and/or review on anatomy and physiology of skin and underlying tissues and blood as related to hemorrhage; observation, communication, and instructional skills; moving and positioning patient on table; hand scrub and putting on surgical gloves; routine for clean up and care of equipment.
2. Slides, filmstrips, films, videotapes, and/or mediated programmed instruction (individual or group) on collecting, checking, and setting up suture table, shaving, scrubbing and preparing surgical site with antiseptic solution; draping wound site, giving local anesthesia, suturing wound, and applying sterile dressing; and making entry on appropriate patient and emergency room records.

3. Hardcover programmed instruction
4. Lecture
5. Discussion
6. Demonstration
7. Practice in simulated patient care unit
8. Practice in work situation
9. Study assignments
10. Written exercises

Training Aids

1. Filmstrips/films/videotapes
2. Mediated programmed instruction
3. Hardcover programmed instruction
4. Slides
5. Wall charts
6. Chalk board
7. Anatomical models
8. Equipment and supplies
9. Instructor's guide
10. Student syllabus
11. References

Examination Modes

1. Response in classroom
2. Paper and pencil test
3. Rating on performance in simulated practice
4. Rating on performance in work situation (feedback)
5. Oral quiz on knowledge related to performance in simulated practice and/or work situation (feedback)

Training Time

- 0:45 hour didactic
- 0:45 hour supervised practice

LEARNING MODULE IM16
INTERNAL INJURIES: EXAMINATION FOR

Tasks

- 150143 Initiate procedure in the absence of a doctor
- 130081 Obtain preliminary medical history, e.g., past/present complaints, allergies, medications
- 110128 Move/position patient with suspected or obvious internal injuries
- 130060 Examine for entry or exit area of shrapnel or bullets
- 140043 Give emergency treatment/first aid for internal injuries
- 140506 Give emergency treatment/first aid for internal hemorrhage
- 140444 Give emergency treatment/first aid for hemo-, pneumothorax
- 140504 Give emergency treatment/first aid for gunshot wounds
- _____ Give emergency treatment/first aid for crush injuries
- 140505 Give emergency treatment/first aid for blast injuries
- 130270 Observe for symptoms of internal hemorrhage
- 130393 Observe and report patient's level of consciousness
- 130110 Perform circulation check, e.g., color, pulse, temperature of skin, capillary return
- 130006 Check blood pressure
- 130099 Observe patient for and describe abnormal respirations
- 130404 Check and count respirations
- 130112 Perform neurological (cranial) check, e.g., pupils, vital signs, patient's response
- 130015 Check pupil reaction to light
- 130264 Observe for symptoms of irritability, restlessness, apprehension
- 130411 Check patient's response to painful stimuli
- 130388 Observe/record or describe characteristics of urine, feces, vomitus, or regurgitation
- 130425 Observe/record or describe characteristics of sputum, mucus
- 130426 Observe/record characteristics of drainage from eyes/ears
- 130437 Observe/describe or report characteristics of convulsions, seizures
- 130436 Evaluate patient's complaints/symptoms of pain
- 130059 Observe and report symptoms of shock

- 120046 Reassure/calm apprehensive/anxious patient
- 120088 Reassure/calm children for examination or treatment
- 120085 Reassure/calm apprehensive parents of pediatric patient
- 150036 Inform doctor/nurse of patient's condition, e.g., description of symptoms, injury, or response
- 150073 Notify medical personnel of treatment needs of patient
- 150064 Write nursing notes
- 150208 Make entry on SF600 "Chronological Record of Medical Care"

Performance Objective (Stimulus)

When an individual has been involved in an accident and shows no external signs and symptoms of injury and in the absence of a physician, nurse, or senior corpsman/technician.

Performance Objective (Behavior)

The corpsman/technician will examine for internal injuries which may or may not be associated with external injuries such as sucking chest wounds, gunshot wounds, and major injuries such as blast and crush, by determining the extent of such injuries; the level of consciousness; the rate, kind, and rhythm of his respirations and pulse; the blood pressure; the presence of paralysis or loss of function of any part of body; the presence of convulsions; abnormal discharge from ears and nose; coughing--especially bloody sputum; vomiting with or without blood; complaint or symptoms of pain; and failure of pupils to react to light. He will reassure an apprehensive or anxious patient or victim, his family, and his friends; notify medical personnel for immediate assistance; and record on the patient's chart or victim's emergency record his findings and the condition of the patient.

Performance Objective (Conditions)

Without supervision and with or without assistance, depending on the need and availability of assistance.

Performance Objective (Criteria)

In accordance with established standard procedures, techniques, and routines.

Performance Objective (Consequence)

Assessment of patient or victim with probable internal injuries.

Performance Objective (Next Action)

Obtain medical aid as soon as possible; in the meantime, give supportive care.

Knowledge and Skills

1. Purpose of examination
2. Anatomy and physiology of vital internal organs subject to traumatic injury and the effects of the injury
3. Relationship of gunshot and sucking chest wounds and of blast and crush injuries to internal injuries.
4. Classifications of unconsciousness and potential causes
5. Normal and abnormal rate, rhythm and type of pulse, and respirations
6. Significance of vomiting, coughing, and presence of blood
7. Relationship of paralysis and convulsions to internal injuries
8. Significance of bleeding or drainage from body orifices
9. Pain as related to internal injury
10. Internal injuries and shock
11. Procedures and techniques for performing circulation and neurological checks and significance of findings
12. Communication techniques for eliciting information from the patient or victim, family, or friends and giving information and encouragement to them and directing assistants.
13. Observation techniques for assessing patient's or victim's condition
14. Routine for notifying medical personnel for assistance in hospital and non-hospital environment.
15. Routine for recording examination findings on hospital and non-hospital victim

Instructional Strategies

1. Pretest and/or review on all knowledges and skills in this unit except those relating sucking chest wounds to hemo-, pneumothorax and blast and crush injuries to internal injuries. They are collectively brought together for the assessment of one condition--namely, internal injuries.

2. Slides, filmstrips, films, videotapes, and/or mediated programmed instruction (individual or group) on procedures, techniques, and routines for examining an individual who has been subjected to trauma as related to internal injuries.
3. Hardcover programmed instruction
4. Lecture
5. Discussion
6. Demonstration
7. Practice in simulated patient care unit
8. Study assignments
9. Written exercises
10. Case studies

Training Aids

1. Filmstrips/films/videotapes
2. Mediated programmed instruction
3. Hardcover programmed instruction
4. Slides
5. Wall charts
6. Chalk board
7. Instructor's guide
8. Student syllabus
9. References

Examination Modes

1. Response in classroom
2. Paper and pencil test
3. Rating on performance in simulated practice
4. Rating on performance in work situation (feedback)
5. Oral quiz on knowledge related to performance in simulated practice and/or work situation (feedback)
6. Case studies

Training Time

0:30 hour didactic

0:20 hour supervised practice in conjunction with Learning Module IM17,
"Internal Injuries: Emergency Treatment for"

LEARNING MODULE IM17
INTERNAL INJURIES: EMERGENCY TREATMENT FOR

Tasks

- 150143 Initiate procedure in the absence of a doctor
- 150036 Inform doctor/nurse of patient's condition, e.g., description of symptoms, injury, or response
- 150073 Notify medical personnel of treatment needs of patient
- 110128 Move/position patient with suspected or obvious internal injuries
 - _____ Restrict patient's physical activity or movements
- 140043 Give emergency treatment/first aid for internal injuries
- 140506 Give emergency treatment/first aid for internal hemorrhage
- 140287 Dress or pack sucking wound of chest
- 140444 Give emergency treatment/first aid for hemo-, pneumothorax
- 140504 Give emergency treatment/first aid for gunshot wound
- 140505 Give emergency treatment/first aid for blast injury
- 130388 Observe/record or describe characteristics of urine, feces, vomitus, or regurgitation
- 130425 Observe/record or describe characteristics of sputum, mucus
 - _____ Keep the victim quiet, warm, and as comfortable as possible
 - _____ Loosen tight clothing, e.g., collar, waistband, belt
 - _____ Restrict fluid intake
- 140389 Administer narcotics
- 120046 Reassure/calm apprehensive/anxious patient
- 120088 Reassure/calm children for examination or treatment
- 120085 Reassure/calm apprehensive parents of pediatric patient
- 150064 Write nursing notes
- 150208 Make entry on SF600 "Chronological Record of Medical Care"

Performance Objective (Stimulus)

When a patient or victim has been examined, internal injuries are probable; a physician, nurse, or senior corpsman/technician is not present; and medical assistance is being awaited.

Performance Objective (Behavior)

The corpsman/technician will work quickly but carefully; loosen tight clothing--collar, waistband, or belt; lower victim's head when vomiting and turn to side to prevent aspiration; remove dentures or other foreign bodies from mouth to prevent aspiration; keep victim quiet, warm, and as comfortable as possible; do not give any fluids orally; prevent any unnecessary movements; prevent any movement of non-splinted fractures; give emergency treatment for sucking chest wounds involving hemopneumothorax, external injuries resulting from gunshot wounds, and blast and crush injuries; prevent victim from sitting, standing, or walking until absolutely safe to do so; watch closely for signs and symptoms of impending shock; administer medication for pain if absolutely necessary; reassure patient or victim, family, and friends; obtain medical assistance quickly; and record on appropriate records the patient's treatment, condition, and response.

Performance Objective (Conditions)

Without supervision and with or without assistance, depending on the patient's or victim's needs and availability of assistance.

Performance Objective (Criteria)

In accordance with established standard procedures, techniques, and routines.

Performance Objective (Consequence)

Interim supportive treatment of patient or victim with internal injuries.

Performance Objective (Next Action)

Refer patient or victim to medical personnel for further treatment.

Knowledge and Skills

1. Purpose of care
2. Procedures and techniques for obtaining medical assistance quickly; preventing aspiration of vomitus, sputum, mucus, teeth, foreign bodies; positioning the patient or victim and keeping him quiet, warm, and as comfortable as possible.

3. Signs and symptoms of impending shock
4. Communication techniques for eliciting information from patient or victim, family, or friends, giving information and encouragement to them, and directing assistants.
4. Observation techniques for assessing patient's or victim's condition and response to treatment.
5. Procedures and techniques for treating sucking chest wounds, resulting in hemopneumothorax and external gunshot wounds, and blast and crush injuries.
6. Routine for notifying medical personnel for assistance in hospital and non-hospital environment.
7. Routine for recording patient or victim's condition, treatment, and response to treatment on appropriate records.

Instructional Strategies

1. Pretest and/or review on all knowledges and skills in this unit. They are collectively brought together for the care of a patient or victim with possible internal injuries threatened by impending shock, and may or may not be complicated by external injuries or wounds.
2. Slides, filmstrips, films, videotapes, and/or mediated programmed instruction (individual or group) on procedures, techniques, and routines for giving care to an individual who may be a hospitalized patient or accident victim who has sustained probable internal injuries with or without external wounds, such as gunshot and sucking chest and external blast and crush injuries.
3. Hardcover programmed instruction
4. Lecture
5. Discussion
6. Demonstration
7. Practice in simulated patient care unit
8. Study assignments
9. Written exercises
10. Case studies

Training Aids

1. Filmstrips/films/videotapes
2. Mediated programmed instruction
3. Hardcover programmed instruction

4. Slides
5. Chalk board
6. Anatomical models
7. Equipment and supplies
8. Instructor's guide
9. Student syllabus
10. References

Examination Modes

1. Response in classroom
2. Paper and pencil test
3. Rating on performance in simulated practice
4. Rating on performance in work situation (feedback)
5. Oral quiz on knowledge related to performance in simulated practice and/or work situation (feedback)
6. Case studies

Training Time

0:30 hour didactic

0:30 hour supervised practice in conjunction with Learning Module IM16,
"Internal Injuries: Examination for"

LEARNING MODULE IM18
STRAINS, SPRAINS, AND DISLOCATIONS: EXAMINATION
AND EMERGENCY TREATMENT

Tasks

- 150143 Initiate treatment procedure in the absence of a doctor
- _____ Examine patient for symptoms of strains
- 130065 Examine for symptoms of sprains
- 130354 Observe for/report signs and symptoms of skeletal dislocation
- 130379 Observe patient's movement, e.g., muscular coordination, posture, balance
- 130435 Observe for/report patient's muscle tone, e.g., rigid, flaccid, spastic, spasms
- 130434 Assess patient's tolerance of exercise or activity
- 130436 Evaluate patient's complaints/symptoms of pain
- 130407 Check color of skin, e.g., cyanosis, blanching, jaundice, mottling
- 130240 Check for swelling of extremities and eyes
- 130252 Palpate joints for swelling, deformity, pain
- 130081 Obtain preliminary medical history, e.g., past/present complaints, allergies, medications
- 140513 Give emergency treatment/first aid for sprains, strains, dislocations, torn ligaments
- 110124 Position extremities to reduce swelling and bleeding
- 140264 Tape ankle, wrist, knee, chest for immobilization
- 140027 Apply/remove sling, e.g., arm, leg
- 140076 Give ice pack treatment
- 140235 Reduce dislocated mandible
- _____ Reduce dislocated joints
- 140398 Give massage to reduce muscle spasms
- 140098 Give massage for relaxation (sedative massage)
- 140020 Apply/change sterile dressings
- 150009 Determine method for moving, transporting patient
- 120046 Reassure/calm apprehensive/anxious patient
- 120088 Reassure/calm children for examination or treatment
- 120085 Reassure/calm parents of pediatric patient

- 150036 Inform doctor/nurse of patient's condition, e.g., description of symptoms, injury or response
- 150073 Notify medical personnel of treatment needs of patient
- 150064 Write nursing notes
- 150208 Make entry on SF600 "Chronological Record of Medical Care"

Performance Objective (Stimulus)

When an individual is suspected of having a strain, sprain, or dislocation and a physician, nurse, or senior corpsman/technician is not present.

Performance Objective (Behavior)

The corpsman/technician will examine the patient or victim for strains of the legs and lower back; sprains of the wrist, knee, and ankle; and dislocations of lower jaw, shoulder, elbow, wrist, finger, thumb, hip, knee and kneecap, ankle, and toes; give emergency care; move and position the patient or victim for transporting; elicit information from the patient or victim, family, and friends and give information and reassurance to them; notify medical personnel of the patient's or victim's symptoms, condition, treatment, response, and needs; and record these on appropriate records.

Performance Objective (Conditions)

Without supervision and with or without assistance, depending on patient's or victim's condition and the availability of assistants.

Performance Objective (Criteria)

In accordance with established standard procedures, techniques, and routines.

Performance Objective (Consequence)

Patient or victim's suspected strain, sprain, or dislocation is confirmed and emergency treatment administered.

Performance Objective (Next Action)

Transfer of patient or victim to medical care.

Knowledge and Skills

1. Anatomy and physiology of the muscular system and skeletal system
2. Strains of legs and lower back: causes, signs and symptoms, emergency treatment, positioning, moving and transporting patient or victim.
3. Sprains of wrist, knee, and ankle: causes, signs and symptoms, emergency treatment, positioning, moving and transporting patient or victim.
4. Dislocations of lower jaw, shoulder, elbow, wrist, finger, thumb, hip, knee and kneecap, ankle, and toes: causes, signs and symptoms, emergency treatment, positioning, moving and transporting patient or victim.
5. Precautions related to treatment of sprains and dislocations
6. Communication techniques for eliciting information from the patient, victim, family, and friends, giving information and encouragement to them, and directing assistants.
7. Observation techniques for assessing the patient's or victim's condition and response to treatment.
8. Routine for reporting patient's or victim's condition, treatment, response, and needs to medical personnel in hospital and non-hospital environment.
9. Routine for recording on appropriate records the patient's or victim's symptoms, condition, treatment, response to treatment, and needs.

Instructional Strategies

1. Pretest and/or review on anatomy and physiology of skeletal and muscular systems; symptoms and treatment of internal hemorrhage; application of bandages; communication and observation skills; routines for reporting to medical personnel and recording on appropriate records.
2. Slides, filmstrips, films, videotapes, and/or mediated programmed instruction (individual or group) on procedures, techniques, and routines for evaluating signs and symptoms; giving emergency treatment; moving, positioning, and transporting patients or victims with strains of legs and back, sprains of wrist, knee, and ankle, and dislocations of lower jaw, shoulder, elbow, wrist, finger, thumb, hip, knee and kneecap, ankle, and toes.
3. Hardcover programmed instruction
4. Lecture
5. Discussion
7. Demonstration
8. Practice in simulated patient care unit
9. Study assignments
10. Written exercises

Training Aids

1. Filmstrips/films/videotapes
2. Mediated programmed instruction
3. Hardcover programmed instruction
4. Slides
5. Wall charts
6. Chalk board
7. Anatomical models
8. Equipment and supplies
9. Instructor's guide
10. Student syllabus
11. References

Examination Modes

1. Response in classroom
2. Paper and pencil test
3. Rating on performance in simulated practice
4. Rating on performance in work situation (feedback)
5. Oral quiz on knowledge related to performance in simulated practice and/or work situation (feedback)
6. Case studies

Training Time

- 1:00 hour didactic
- 1:00 hour supervised practice

LEARNING MODULE IM19
FRACTURES: EXAMINATION AND EMERGENCY TREATMENT FOR

Tasks

- 150143 Initiate treatment procedures in the absence of a doctor
- 130081 Obtain preliminary medical history, e.g., past/present complaints, allergies, medications
- 130024 Examine for symptoms of fractures
 - _____ Examine for symptoms of fractures of the extremities
 - _____ Examine for symptoms of fractures of the skull and face
 - _____ Examine for symptoms of fractures of the collarbone
 - _____ Examine for symptoms of fractures of the spine
 - _____ Examine for symptoms of fractures of the pelvis
 - _____ Examine for symptoms of fractures of the ribs
- 130414 Check skin for air in tissue (crepitus)
- 130247 Palpate costovertebral angle for deformities/pain
- 130252 Palpate joints for swelling, deformity, pain
- 130434 Assess patient's tolerance of exercise or activity
- 130110 Perform circulation check, e.g., color, pulse, temperature of skin, capillary return
- 130407 Check color of skin, e.g., cyanosis, blanching, jaundice, mottling
- 130112 Perform neurological (cranic) checks, e.g., pupils, vital signs, patient response
- 130393 Observe/report patient's level of consciousness
- 130015 Check pupil reaction to light
- 130426 Observe/record or describe characteristics of drainage from eyes/ears
- 130059 Observe for/report symptoms of shock
- 130271 Observe for/report symptoms of external hemorrhage
- 130436 Evaluate patient's complaints or symptoms of pain
- 130411 Check patient's response to painful stimulus
- 140299 Give emergency treatment/first aid for fractures
 - _____ Give emergency treatment/first aid for fractures of extremities
 - _____ Give emergency treatment/first aid for fractures of skull and face
 - _____ Give emergency treatment/first aid for fractures of collarbone
 - _____ Give emergency treatment/first aid for fractures of spine

_____ Give emergency treatment/first aid for fractures of ribs
_____ Give emergency treatment/first aid for fractures of pelvis
110124 Position extremities to reduce swelling or bleeding
140044 Give emergency treatment/first aid for external hemorrhage
140047 Give emergency treatment/first aid for shock
140263 Apply rib belt
140435 Apply finger/hand splint
140027 Apply/remove sling, e.g., arm, leg
140023 Apply elastic bandage
140265 Apply/change bandages, e.g., roller, triangle, Kurlex
140033 Apply traction splints
260011 Fabricate fracture splint
140264 Tape ankle, wrist, knee, chest for immobilization
110125 Move/position patient with suspected fractures of extremities
150009 Determine method of moving/transporting patient
120046 Reassure/calm apprehensive/anxious patient
120088 Reassure/calm children for examination or treatment
120085 Reassure apprehensive parents of pediatric patient
150036 Inform doctor/nurse of patient's condition, e.g., description of injury, symptoms, or response
150073 Notify medical personnel of treatment needs for patient
150064 Write nursing notes
150208 Make entry on SF600 "Chronological Record of Medical Care"

Performance Objective (Stimulus)

When an individual is suspected of having a fracture and a physician, nurse, or senior corpsman/technician is not present.

Performance Objective (Behavior)

The corpsman/technician will examine the patient or victim for fractures of the extremities, skull and face, collarbone, ribs, spine, and pelvis; give emergency treatment for the fracture; move and position the patient or victim for transporting; elicit information from the patient or victim, family, and friends, and give information and reassurance to them; notify medical personnel

of the patient's or victim's symptoms, condition, treatment, response and needs; and record these on appropriate records.

Performance Objective (Conditions)

Without supervision and with or without assistance, depending on patient's or victim's condition and the availability of assistants.

Performance Objective (Criteria)

In accordance with established standard procedures, techniques, and routines.

Performance Objective (Consequence)

Patient's or victim's suspected fracture is confirmed and emergency treatment administered.

Performance Objective (Next Action)

Transfer patient or victim to medical care.

Knowledge and Skills

1. Anatomy and physiology of musculoskeletal system
2. Classification of fractures: simple, compound, greenstick fissure, oblique and transverse, impacted, etc.
3. Causes of fractures: blows, opposing forces on each end of bone, crushes, accidents, falls, etc.
4. Indications of fracture: suspected due to injury, something "popped," acute tenderness, pain and swelling; may be deformity present; grating sensation; external hemorrhage and torn soft tissue.
5. Fractures of the extremities: signs, symptoms, treatment, moving, positioning and transporting victims with fractures of upper arm, elbow joint, wrist and forearm, bones of the hand, hip, knee, lower leg and foot, and toes.
6. Fractures of the skull and face: signs, symptoms, treatment, moving and transporting victims with fractures of skull, nose, upper jaw, and lower jaw.
7. Fracture of the collarbone: signs, symptoms, treatment, moving, positioning and transporting victims with collarbone fractures.
8. Fractured spine: signs, symptoms, treatment, moving, positioning, transporting victim with broken neck and/or back.

9. Fracture of ribs: signs, symptoms, treatment, moving, positioning and transporting victim with fractured ribs.
10. Fractures of the pelvis: signs, symptoms, treatment, positioning, moving and transporting victims with fractured pelvis.
11. Precautions in treatment of each kind of fracture
12. Complications resulting from fractures
13. Symptoms and treatment of shock
14. Symptoms and treatment of external hemorrhage
15. Communication techniques for eliciting information from the patient, victim, family, and friends, giving information and encouragement to them, and directing assistants.
16. Observation techniques for assessing the patient's or victim's condition and response to treatment
17. Routine for reporting patient's or victim's condition, treatment, response and needs to medical personnel in hospital and non-hospital environment.
18. Routine for recording on appropriate records the patient's or victim's symptoms, condition, treatment, response to treatment, and needs.

Instructional Strategies

1. Pretest and/or review on anatomy and physiology of skeletal and muscular systems; symptoms and treatment of shock and hemorrhage; neurological, skin and circulation checks; application of bandages; communication and observation skills; routines for reporting to medical personnel and recording on appropriate records for patient or victim.
2. Slides, filmstrips, films, videotapes, and/or mediated programmed instruction (individual or group) on procedures, techniques, and routines for evaluating signs and symptoms, giving emergency care, moving, positioning and transporting patients or victims with fractures of extremities, skull and face, collarbone, ribs, spine, and pelvis, and precautions related to each.
3. Hardcover programmed instruction
4. Lecture
5. Discussion
6. Demonstration
7. Practice in simulated patient care unit
8. Study assignments
9. Written exercises

Training Aids

1. Filmstrips/films/videotapes
2. Mediated programmed instruction
3. Hardcover programmed instruction
4. Slides
5. Wall charts
6. Chalk board
7. Anatomical models
8. Equipment and supplies
9. Instructor's guide
10. Student syllabus
11. References

Examination Modes

1. Response in classroom
2. Paper and pencil test
3. Rating on performance in simulated practice
4. Rating on performance in work situation (feedback)
5. Oral quiz on knowledge related to performance in simulated practice and/or work situation (feedback)

Training Time

- 1:30 hours didactic
- 3:00 hours supervised practice

LEARNING MODULE IM20
SPINAL CORD AND HEAD INJURIES: EXAMINATION AND
EMERGENCY TREATMENT

Tasks

- 150143 Initiate treatment procedures in the absence of a doctor
- 130081 Obtain preliminary medical history, e.g., past/present complaints, allergies, medications
- 130064 Examine for symptoms of spinal cord injuries
- 130411 Check patient's response to painful stimulus
- 130436 Evaluate patient's complaints or symptoms of pain
- 130393 Observe/report patient's level of consciousness
- 130112 Perform neurological (cranic) check, e.g., pupils, vital signs, patient's response
- 130059 Observe for/report symptoms of shock
- 130426 Observe/record or describe characteristics of drainage from eyes/ears
- 140465 Give emergency treatment/first aid for spinal cord injury
- 140048 Give emergency treatment/first aid for head injury
- 110126 Move/position patient with suspected spinal fractures or cord injuries
- 110116 Position patient who has symptoms of shock
- 120046 Reassure/calm apprehensive/anxious patient
- 120088 Reassure/calm children for examination or treatment
- 120085 Reassure apprehensive parents of pediatric patient
- 150009 Determine method for moving/transporting patients
- 110127 Move/position patient with head injuries
- 150036 Inform doctor/nurse of patient's condition, e.g., description of injury, symptoms, or response
- 150073 Notify medical personnel of treatment needs for patient
- 150064 Write nursing notes
- 150208 Make entries on SF600 "Chronological Record of Medical Care"

Performance Objective (Stimulus)

When an individual is suspected of having a spinal cord or head injury and a physician, nurse, or senior corpsman/technician is not present.

Performance Objective (Behavior)

The corpsman/technician will examine for spinal cord injuries associated with fractures of the back and neck by determining the presence of sensation in the feet and in the hands; for whiplash injuries by assessing the loss of consciousness and the type of pain; and for head injuries by assessing the loss of and level of consciousness, degree of headache, presence of nausea and vomiting and presence of shock. He will give emergency care for each type of injury with emphasis on patient or victim handling and transporting; elicit information from the patient or victim, family and friends, give information and reassurance to them, and direct his assistants; notify medical personnel of the patient's or victim's symptoms, condition, treatment, response, and needs; and record these on the appropriate records.

Performance Objective (Conditions)

Without supervision and with assistants, preferably technical assistants.

Performance Objective (Criteria)

In accordance with established standard procedures, techniques, and routines.

Performance Objective (Consequence)

Patient's or victim's suspected spinal and/or head injury will be confirmed and emergency treatment administered.

Performance Objective (Next Action)

Transfer patient or victim to medical care.

Knowledge and Skills

1. Anatomy and physiology of the spinal cord and brain
2. Injuries to the spinal cord: signs and symptoms, treatment, handling and transporting patients or victims with upper and lower spinal cord injuries.
3. Head injuries: signs and symptoms, treatment, handling and transporting patients or victims with simple concussion, congestion of the brain and brain contusions.

4. Precautions in the treatment, handling, and transporting of patients or victims with spinal cord and head injuries.
5. Communication techniques for eliciting information from the patient, victim, family and friends, giving information and encouragement to them, and directing assistants.
6. Observation techniques for assessing the patient's or victim's condition and response to treatment.
7. Routine for reporting patient's or victim's condition, treatment, response, and needs to medical personnel in hospital and non-hospital environment.
8. Routine for recording on appropriate records the patient's or victim's symptoms, condition, treatment, response to treatment, and needs.

Instructional Strategies

1. Pretest and/or review on anatomy and physiology of the brain and spinal cord; symptoms and treatment of shock; communication and observation skills; routines for reporting to medical personnel and recording on appropriate records.
2. Slides, filmstrips, films, videotapes, and/or mediated programmed instruction (individual or group) on procedures, techniques, and routines for examining for spinal cord and head injuries, emergency treatment, and handling and transporting patient or victim. Precautions related to treatment, handling, and transporting.
3. Hardcover programmed instruction
4. Lecture
5. Discussion
6. Demonstration
7. Practice in simulated patient care unit
8. Study assignments
9. Written exercises
10. Case studies

Training Aids

1. Filmstrips/films/videotapes
2. Mediated programmed instruction
3. Hardcover programmed instruction
4. Slides
5. Wall charts

6. Chalk board
7. Anatomical models
8. Equipment and supplies
9. Instructor's guide
10. Student syllabus
11. References

Examination Modes

1. Response in classroom
2. Paper and pencil test
3. Rating on performance in simulated practice
4. Rating on performance in work situation (feedback)
5. Oral quiz on knowledge related to performance in simulated practice and/or work situation (feedback)
6. Case studies

Training Time

0:30 hour didactic

0:45 hour supervised practice

LEARNING MODULE IM21
BURNS: EXAMINATION AND EMERGENCY TREATMENT

Tasks

- 150143 Initiate treatment procedures in the absence of a doctor
- 130081 Obtain preliminary medical history, e.g., past/present complaints, allergies, medications
- 130033 Examine and describe burns, i.e., source, area, degree
- 130436 Evaluate patient's complaints/symptoms of pain
- 140449 Give emergency treatment/first aid for thermal burn
- 140447 Give emergency treatment/first aid for chemical burn
- 140450 Give emergency treatment/first aid for electrical burn
- 140032 Administer topical, skin/lip medications, e.g., ointment, powder
- 140020 Apply/change sterile dressing
- 140389 Administer narcotics
- 140275 Force fluid intake
- 130005 Record/tally fluid intake and output
- 130560 Observe for/report decreased urine output of patients susceptible to renal shutdown
- 150193 Evaluate patient's inability to void
- 130204 Observe for/report or describe symptoms of irritability, restlessness, apprehension
- 130393 Observe for/report patient's level of consciousness
- 130056 Observe for/report symptoms of shock
- 140047 Give emergency treatment or first aid for shock
- 140020 Apply/change sterile dressing
- 120046 Reassure/calm apprehensive/anxious patient
- 120088 Reassure/calm children for examination or treatment
- 120085 Reassure apprehensive parents of pediatric patient
- 120113 Provide support/reassure family of patient's condition and response
- 150073 Notify medical personnel of treatment needs of patient
- 150036 Inform doctor/nurse of patient's condition, e.g., description of symptoms, injury, or response
- 150208 Make entry on SF600 "Chronological Record of Medical Care"
- 150064 Write nursing notes

Performance Objective (Stimulus)

When an individual has been burned and in the absence of a physician, nurse, and senior corpsman/technician.

Performance Objective (Behavior)

The corpsman/technician will examine and assess the burns as to extent and body areas affected, degree of burns--first, second, third, fourth degree; cause of burns--thermal, electrical, chemical; exercise caution in minimizing extent and degree of burns, especially burns caused by high intensity heat and blast of superheated air which burn or sear lung tissue; treat the burns according to extent, kind, and degree focusing on cleaning, dressing, relief of pain, prevention and treatment of shock, maintenance of body fluids and prevention of infection; communicate with the victim about his condition and treatment and allay his apprehension or anxiety and that of his family; report to medical staff on patient's condition and treatment and record observations, treatment, and victim's response on appropriate records.

Performance Objective (Conditions)

Without supervision and with assistance or technical assistance if available and as required by patient's condition.

Performance Objective (Criteria)

In accordance with established standard procedures, techniques, and routines for assessing burns and giving emergency treatment for them.

Performance Objective (Consequence)

Victim will have received emergency treatment for burn.

Performance Objective (Next Action)

Refer to physician for further treatment.

Knowledge and Skills

1. Anatomy and physiology of the skin and underlying tissues and the excretory and respiratory systems as related to burns.

2. Common causes of burns--thermal, electric, chemical
3. Degree of burn--first, second, third, fourth
4. Effects of second, third, and fourth degree burns on body organs and functions, e.g., kidneys, lungs.
5. Observation techniques for assessing patient's or victim's condition and response to treatment.
6. Communication techniques for encouraging and instructing conscious or semi-conscious victim, directing assistants, and reassuring victim's family.
7. Procedures and techniques for emergency treatment of first, second, third, and fourth degree burns caused by thermal, electrical, and chemical agents--remove patient or victim from heat contact; administer medications for pain and prevent infection; treat shock; remove clothing and debris; keep patient warm, applying surgical clean or sterile dressings; encourage fluids and ready victim for transport to medical facility.
8. Routine for reporting to medical personnel in hospital or in emergency situation relative to victim's condition and treatment.
9. Routine for recording victim's condition, cause of burn, and treatment on appropriate records.

Instructional Strategies

1. Pretest and/or review on anatomy and physiology of skin and underlying tissues and the excretory and respiratory systems; observation and communication skills; administration of medication; forcing fluid intake; treating shock; applying heat and needed surgical dressings; and routines for reporting and recording.
2. Slides, filmstrips, films, videotapes, and/or mediated programmed instruction (individual or group) on procedures, techniques, and routines for emergency care of first, second, third, and fourth degree burns--contraindications and precautions related to treatment.
3. Hardcover programmed instruction
4. Lecture
5. Discussion
6. Demonstration
7. Practice in simulated patient care unit
8. Practice in work situation
9. Written exercises
10. Case studies

Training Aids

1. Filmstrips/films/videotapes
2. Mediated programmed instruction
3. Hardcover programmed instruction
4. Slides
5. Chalkboard
6. Wall charts
7. Anatomical models
8. Equipment and supplies
9. Instructor's guide
10. Student syllabus
11. References

Examination Modes

1. Response in classroom
2. Paper and pencil test
3. Rating on performance in simulated practice
4. Rating on performance in work situation (feedback)
5. Oral quiz on knowledge related to performance in simulated practice and/or work situation (feedback)
6. Case studies

Training Time

0:45 hour didactic

1:00 hour supervised practice

LEARNING MODULE IM22
HEAT CRAMPS, HEAT EXHAUSTION, AND HEAT STROKE: EXAMINATION
AND EMERGENCY TREATMENT

Tasks

- 150143 Initiate treatment procedures in the absence of a doctor
- 130081 Obtain preliminary medical history, e.g., past/present complaints, allergies, medications
- _____ Examine for signs and symptoms of heat cramps, heat exhaustion, and heat stroke
- 130436 Evaluate patient's complaints/symptoms of pain
- 130435 Observe/report patient's muscle tone, e.g., rigid, flaccid, spastic, spasms
- 130110 Perform circulation check, e.g., color, pulse, temperature of skin, capillary return
- 130410 Check for sweating/diaphoresis
- 130264 Observe for symptoms of irritability, restlessness, apprehension
- 130393 Observe and report patient's level of consciousness
- 130016 Check radial (wrist) pulse
- 130404 Check/count respirations
- 130099 Observe patient for and describe abnormal respirations
- 130006 Check blood pressure
- 130014 Check patient's temperature
- _____ Give emergency treatment/first aid for heat cramps
- 140459 Give emergency treatment/first aid for heat exhaustion
- 140458 Give emergency treatment/first aid for heat stroke
- 120046 Reassure/calm apprehensive/anxious patient
- 120113 Provide support/reassure family of patient's condition and response
- 150036 Inform doctor/nurse of patient's condition, e.g., description of symptoms, injury, or response
- 150073 Notify medical personnel of treatment needs of patient
- 150064 Write nursing notes
- 150208 Make entry on SF600 "Chronological Record of Medical Care"

Performance Objective (Stimulus)

When an individual is suspected of having heat cramps, heat exhaustion, or heat stroke and a physician, nurse, or senior corpsman/technician is not present.

Performance Objective (Behavior)

The corpsman/technician will examine and determine if the patient has heat cramps, heat exhaustion, or heat stroke by evaluating the presence, location, and kind of pain; determining the presence of faintness, dizziness, fatigue, lassitude, and exhaustion; determining if the skin is flushed and dry, white, cold, clammy with profuse perspiration, or deathly gray; determining if the pulse is rapid and thready, the respirations rapid and shallow, and the temperature is normal, slightly elevated, or very high; and if there are brief periods of unconsciousness. Depending upon the findings, he will give emergency care for heat cramps, heat exhaustion, or heat stroke (sunstroke); reassure the apprehensive or anxious patient or victim; notify medical personnel of the patient's symptoms, condition, treatment, response, and further needs and record these on the appropriate records.

Performance Objective (Conditions)

Without supervision and with or without assistance, depending on the patient's condition and the availability of assistants.

Performance Objective (Criteria)

In accordance with established standard procedures, techniques, and routines for examining for heat cramps, heat exhaustion, and heat stroke, and giving the respective emergency treatment for each.

Performance Objective (Consequence)

The patient or victim will be diagnosed accurately and gain the proper emergency care.

Performance Objective (Next Action)

The patient or victim will be transferred to medical care.

Knowledge and Skills

1. Purpose of examination and treatment

2. Heat cramps:

Causes--loss of salt due to heavy fluid intake

Symptoms--severe muscle cramps or pains especially in calves of legs and abdomen; faintness, dizziness, and exhaustion

Treatment--salt tablets with water

3. Heat exhaustion:

Causes--high environmental temperature, accumulation of blood in skin to increase body's cooling efficiency results in decreased heart output and blood in the brain

Symptoms--affects women more frequently than men; fatigue, lassitude, fainting followed by profuse clammy perspiration, whiteness of skin and loss of consciousness--usually brief--cold and clammy skin, weak and thready pulse and shallow breathing, normal or slightly elevated temperature

Treatment--remove to cool comfortable place, loosen clothing, cool body by placing cool, moist cloth on forehead and wrist and an electric fan, aromatic spirits of ammonia inhalations; if victim does not respond rapidly, elevate legs above body and bandage tightly, give salt orally and/or rectally

4. Heat stroke (sunstroke):

Causes--occurs more often in males, common in elderly people and alcoholics; excessive physical exertion in environment with high humidity and temperature, and cessation of sweating

Symptoms--collapse, skin very flushed, very dry and very hot; and if profound, circulatory collapse, face has deathly gray pallor, very high temperature (105° or more)

Treatment--grave emergency--cold tub of water with ice, remove when temperature reaches 100°, wrap in wet cold sheets and expose to several electric fans; repeat iced tub, etc.; if temperature rises, give ice water enema or rectal irrigation, place in semi-reclining position--quick temperature reduction is a must

5. Communication techniques for eliciting information from patient or victim, family and friends, giving information and encouragement to them, and directing assistants.
6. Observation techniques for assessing patient's or victim's condition and response to treatment.
7. Routine for reporting to medical personnel in hospital and non-hospital environment the patient's or victim's symptoms, condition, treatment, response, and needs.
8. Routine for recording patient's or victim's symptoms, condition, treatment, and response on appropriate records.

Instructional Strategies

1. Pretest and/or review on communication and observation skills; procedures, techniques, and routines for vital signs, circulation check, skin check, and temperature taking; routine procedures and techniques for reporting to supervisory personnel and recording.
2. Slides, filmstrips, films, videotapes, and/or mediated programmed instruction (individual or group) on causes, signs, and symptoms and emergency treatment for heat cramps, heat exhaustion, and heat stroke (sunstroke).
3. Hardcover programmed instruction
4. Lecture
5. Discussion
6. Demonstration
7. Practice in simulated patient care unit
8. Practice in work situation
9. Study assignments
10. Written exercises
11. Case studies

Training Aids

1. Filmstrips/films/videotapes
2. Mediated programmed instruction
3. Hardcover programmed instruction
4. Slides
5. Chalk board
6. Equipment and supplies
7. Student syllabus
8. References

Examination Modes

1. Response in classroom
2. Paper and pencil test
3. Rating on performance in simulated practice
4. Rating on performance in work situation (feedback)

5. Oral quiz on knowledge related to performance in simulated practice and/or work situation (feedback)
6. Case studies

Training Time

0:45 hour didactic

0:45 hour supervised practice

LEARNING MODULE IM23
COLD INJURY: EXAMINATION AND EMERGENCY TREATMENT

Tasks

- 150143 Initiate treatment procedure in the absence of a doctor
- 130081 Obtain preliminary medical history, e.g., past/present complaints, allergies, medications
- 140457 Give emergency treatment/first aid for cold injury, e.g., frostbite
- 130407 Check color of skin, e.g., cyanosis, blanching, jaundice, mottling
- 130110 Perform circulation check, e.g., color, pulse, temperature of skin, capillary return
- 130412 Check patient's response to touch, pressure, temperature
- 130411 Check patient's response to painful stimuli
- 130145 Examine/report symptoms of cellulitis
- 130436 Evaluate patient's complaints/symptoms of pain
- _____ Keep the victim quiet, warm, and as comfortable as possible
- _____ Loosen tight clothing, e.g., collars, waistbands, belts
- 110124 Position extremities to reduce swelling or bleeding
- 140031 Apply compresses/soaks/packs
- 140275 Force fluid intake
- 140389 Administer narcotics
- 140020 Apply/change sterile dressings
- 120046 Reassure/calm apprehensive/anxious patient
- 120088 Reassure/calm children for examination or treatment
- 120085 Reassure apprehensive parents of pediatric patient
- 150036 Inform doctor/nurse of patient's condition, e.g., description of symptoms, injury, and response
- 150073 Notify medical personnel of treatment needs of patient
- 150064 Write nursing notes
- 150208 Make entry on SF600 "Chronological Record of Medical Care"

Performance Objective (Stimulus)

When an individual has been exposed to extensive cold and is complaining of abnormal feeling in ears, nose, hands, and feet and a physician, nurse, or senior corpsman/technician is not present.

Performance Objective (Behavior)

The corpsman/technician will examine the patient or victim for tingling sensation, numbness, pain, violet red skin, followed by constant burning or itching, loss of sensation and a dead white skin; protect the patient or victim from further injury, remove restrictive garments, immerse the part in warm water, restrict walking, give hot fluids--especially coffee--give sedative for pain, elevate and lower rhythmically the affected extremity; avoid rough handling, exposure to open fire, cold water soaks, rubbing with snow, and smoking; apply dry sterile dressing but only in case of gangrene; reassure the apprehensive or anxious patient or victim, his family and friends, notify medical personnel of patient's or victim's symptoms, condition, treatment, response, and further needs and record these on appropriate records.

Performance Objective (Conditions)

Without supervision and with or without assistance, depending upon condition of victim and availability of assistance.

Performance Objective (Criteria)

In accordance with established standard procedures, techniques, and routines.

Performance Objective (Consequence)

Victim of frostbite will be examined properly and given correct emergency care.

Performance Objective (Next Action)

Transfer patient or victim to physician's care.

Knowledge and Skills

1. Effect of extreme cold on tissues and circulatory functions
2. Symptoms of cold injury (frostbite): early symptoms--tingling sensation, numbness, pain, violet red skin; later symptoms--chilblains, loss of sensation, dead white skin, and gangrene.
3. Treatment of cold injury: protect from further injury, remove garment restriction, and immerse in warm water, give hot fluids--especially coffee--give sedative for pain, elevate part slightly and later rhythmically lower and raise it, encourage victim to move part, avoid pressure on part, rough handling, exposure to open fire, cold soaks or rubbing with snow, wet dressings, and smoking.

4. Communication techniques for eliciting information from patient or victim, family or friends, giving information and encouragement to them, and directing assistants.
5. Observation techniques for assessing patient's or victim's condition and response to treatment.
6. Routine for reporting to medical personnel in hospital and non-hospital environment patient's or victim's symptoms, condition, treatment, response, and needs.
7. Routine for recording patient's or victim's symptoms, condition, treatment, and response on appropriate records.

Instructional Strategies

1. Pretest and/or review on observation and communication skills; anatomy and physiology of ears, nose, feet, and hands and the circulatory system; procedures, techniques, and routines for application of heat and cold, positioning and exercising, giving medication, applying dressings, and reporting to medical personnel and recording on appropriate records.
2. Slides, filmstrips, films, videotapes, and/or mediated programmed instruction (individual or group) on procedures, techniques, and routines for examining and diagnosing frostbite and treating it. Precautions related to treatment.
3. Hardcover programmed instruction
4. Lecture
5. Discussion
6. Demonstration
7. Practice in simulated patient care unit
8. Study assignments
9. Written exercises
10. Case studies

Training Aids

1. Filmstrips/films/videotapes
2. Mediated programmed instruction
3. Hardcover programmed instruction
4. Slides
5. Chalk board
6. Equipment and supplies

7. Instructor's guide
8. Student syllabus
9. References

Examination Modes

1. Response in classroom
2. Paper and pencil test
3. Rating on performance in simulated practice
4. Rating on performance in work situation (feedback)
5. Oral quiz on knowledge related to performance in simulated practice and/or work situation (feedback)
6. Case studies

Training Time

0:30 hour didactic

0:30 hour supervised practice

LEARNING MODULE IM24
BITES AND STINGS: EXAMINATION OF

Tasks

- 150143 Initiate procedure in the absence of a doctor
- 130081 Obtain preliminary medical history, e.g., past/present complaints, allergies, medications
- 130049 Examine for presence of or contact with lice, fleas, ticks, leaches
- 130021 Examine for animal or human bites
- 130063 Examine for symptoms of snake bites
- 130438 Identify species of snake by bite impression and systemic reaction
- 130436 Evaluate patient's complaints/symptoms of pain
- 130407 Check color of skin, e.g., cyanosis, blanching, jaundice, mottling
- 130409 Check temperature of skin
- 130393 Observe for level of consciousness
- 130059 Observe and report symptoms of shock
- 120046 Reassure/calm apprehensive/anxious patient
- 120088 Reassure/calm children for examination or treatment
- 120085 Reassure apprehensive parents of pediatric patient
- 150036 Inform doctor/nurse of patient's condition, e.g., description of symptoms, injury, or response
- 150073 Notify medical personnel of treatment needs of patient
- 150064 Write nursing notes
- 150208 Make entry on SF600 "Chronological Record of Medical Care"

Performance Objective (Stimulus)

When an individual has been bitten or stung, and a physician, nurse, or senior corpsman/technician is not present.

Performance Objective (Behavior)

The corpsman/technician will communicate with the patient or victim, family and friends as to the source of the sting or bite; in the case of bee, wasp, or hornet stings, examine for redness, swelling, heat, aching, itching, presence of stinger and anaphylactic shock; in case of black widow spider or

tarantula bites, examine for abdominal pain with or without vomiting, partial state of collapse, dilated pupils, generalized swelling of face and extremities, and possible convulsions; in case of scorpions, examine for burning sensation at site of sting with pain spreading to entire limb, headache, dizziness, nausea, vomiting, increased salivation, shock, followed by coma; in case of pit viper bites, examine for severe local pain accompanied by swelling and dark purplish discoloration of skin, fang marks, weakness, shortness of breath, increasing lassitude, leading to unconsciousness, dimness of vision, rapid pulse, and nausea and vomiting--the coral snake bite has same symptoms plus drowsiness into deep sleep and unconsciousness and without severe local pain and swelling; in case of stingrays (whiprays), examine for painful swelling which becomes black and blue, usually deep jagged lacerations that bleed profusely, and prostration; in case of saltwater catfish, examine for similar symptoms of stingray, except wound will be more puncture-like; in case of jellyfish (Portuguese man-of-war), examine for sting and generalized symptoms of illness; and in the case of animal or human bites, examine for torn, lacerated and bruised tissues. He will reassure the victim, family and friends, notifying medical personnel of victim's symptoms and condition, and record on appropriate records.

Performance Objective (Conditions)

Without supervision and with or without assistance, depending on condition of patient or victim and availability of assistants.

Performance Objective (Criteria)

In accordance with standard examination procedures, techniques, and routines using good observation techniques and precautionary measures in the case of vermin.

Performance Objective (Consequence)

Preliminary integument examination with tentative diagnosis.

Performance Objective (Next Action)

Institute care in the absence of doctor, nurse, or senior corpsman/technician.

Knowledge and Skills

1. Purpose of examination
2. Local and generalized reactions of body to bites and stings and their significance
3. Potential complications of bites and stings by different insects and animals, including marine animals.
4. Difference in hornet, wasp, and bee stings--bee is disemboweled with stinger in victim's body.
5. Identification of black widow and tarantula spiders, scorpions, poisonous and non-poisonous snakes and their bites.
6. Identification of marine animals--stingray, jellyfish, and saltwater catfish and injuries caused by them.
7. Communication techniques for eliciting information from victim, family and friends, and for giving information to them and reassuring them.
8. Observation techniques coupled with communication techniques to determine kind of bite or sting.
9. Routine for notifying medical personnel
10. Routine for recording victim's condition and examination on appropriate records

Instructional Strategies

1. Pretest and/or review on anatomy and physiology of the skin; observation and communication skills; anaphylactic shock; systemic reaction; routines for reporting.
2. Slides, filmstrips, films, videotapes, and/or mediated programmed instruction (individual or group) on procedures, techniques, and routines for determining kind of sting or bite based on observation and communication input.
3. Hardcover programmed instruction
4. Lecture
5. Discussion
6. Demonstration
7. Practice in simulated patient care unit
8. Study assignments
9. Written exercises
10. Case studies

Training Aids

1. Filmstrips/films/videotapes
2. Mediated programmed instruction
3. Hardcover programmed instruction
4. Slides
5. Wall charts
6. Chalk board
7. Instructor's guide
8. Student syllabus
9. References

Examination Modes

1. Response in classroom
2. Paper and pencil test
3. Rating on performance in simulated practice
4. Rating on performance in work situation (feedback)
5. Oral quiz on knowledge related to performance in simulated practice and/or work situation (feedback)
6. Case studies

Training Time

0:45 hour didactic

0:30 hour supervised practice in conjunction with Learning Module IM25,
"Bites and Stings: Emergency Treatment for"

LEARNING MODULE 1M25
BITES AND STINGS: EMERGENCY TREATMENT FOR

Tasks

- 150143 Initiate procedure in the absence of a doctor
- 110081 Position/hold patient for examination, treatment, surgery
- 110043 Prepare skin site with antiseptic solution prior to incision/
suturing/treatment/examination
- 140456 Give emergency treatment/first aid for insect bite
- 140455 Give emergency treatment/first aid for animal/human bite
- 140454 Give emergency treatment/first aid for snake bite
- 140507 Give emergency treatment/first aid for anaphylactic shock
- 140020 Apply/change sterile dressing
- 140011 Administer subcutaneous medication
- 140005 Administer intramuscular medication
- 130436 Evaluate patient's complaints/symptoms of pain
- 130382 Observe/record patient's physical and emotional response to
treatment/diagnostic procedure
- 120046 Reassure/calm apprehensive/anxious patient
- 120088 Reassure/calm children for examination/treatment
- 120085 Reassure apprehensive parents of pediatric patient
- 120113 Provide support/reassure family of patient's condition/progress
- 120012 Explain physiological basis for therapy/treatment to patient/family
- 120083 Counsel patient/family on when/where to seek medical care
- 150036 Inform doctor/nurse of patient's condition, e.g., description of
symptoms, injury, or response
- 150073 Notify medical personnel of treatment needs of patient
- 150064 Write nursing notes
- 150208 Make entry on SF600 "Chronological Record of Medical Care"
- 340068 Notify health authorities of animal bite incidents

Performance Objective (Stimulus)

When a victim or patient has been examined and is found to have a poison injected by stings or bites, and a physician, nurse, or senior corpsman/technician is not present.

Performance Objective (Behavior)

The corpsman/technician will initiate emergency treatment--for wasp, hornet, and bee stings, tease bee stinger out with a sideways motion, give warm Epsom salts soaks, give an antihistamine for local itching, and if no symptoms of anaphylactic shock, send home with instructions and preventive information; in case of symptoms, refer to physician; for black widow spiders and tarantulas, place tourniquet above bite, make crisscross incision over bite and suck out venom, give intravenous calcium lactate or calcium gluconate to relax muscle spasm, and an antivenom to limit toxic symptoms; for scorpions, the early administration of antivenom lowers mortality; for snake bites, apply tourniquet above bite, crisscross incision 1/4 inch deep over bite and suck out venom, as swelling grows make additional incisions (30 to 40 may be required), if swelling moves above tourniquet place another tourniquet higher up, keep limb lower than body; give 50 milliliters of antivenom into bite and surrounding tissues and rush to medical care; for stingray, irrigate with salt-water, apply tourniquet above sting, remove visible portion of stinger, immerse leg in as hot water as can be borne for 30 to 60 minutes, suture if necessary, give antibiotics and sedatives; for saltwater catfish--same as snake bite; and for jellyfish, soak limb in dilute ammonia water followed by hot Epsom salts soaks, elevate leg with ice bags to swollen groin glands, and give aspirin or other medication for pain. He will communicate with the victim, victim's family and friends to elicit information about the bite or sting and to give information to them and reassure them; notify medical personnel except in case of uncomplicated wasp, hornet, or bee sting; record victim's condition, treatment, and response to treatment on appropriate records and report same to medical personnel and report animal bites to health authorities.

Performance Objective (Conditions)

Without supervision and with or without assistance, depending on victim's condition and availability of assistance.

Performance Objective (Criteria)

In accordance with established standard procedures, techniques, and routines for treating each kind of sting and bite and reporting and recording it.

Performance Objective (Consequence)

Emergency treatment for stings and bites will be given to patient or victim.

Performance Objective (Next Action)

Transfer victim to medical care except in case of uncomplicated wasp, hornet, or bee stings, then send home with instructions.

Knowledge and Skills

1. Identification of poisonous and non-poisonous bites and stings and anaphylactic shock.
2. Purpose of treatment
3. Physiological basis for therapy or treatment
4. Emergency treatment and first aid for poisonous and non-poisonous bites and stings and for anaphylactic shock.
5. Precautionary measures relative to the treatment
6. Communication techniques for giving information to and eliciting it from patient and/or family and reporting to supervisory personnel and directing assistants.
7. Observation techniques for assessing patient's condition and response to treatment
8. Routine for notifying medical personnel of patient's or victim's treatment, response to treatment, and condition and health authorities of animal bites.
9. Routine for recording patient's or victim's treatment, response to treatment, and condition on appropriate records.

Instructional Strategies

1. Pretest and/or review on observation, examination, and tentative diagnosis of skin injuries; communication and observation skills; examination and treatment of anaphylactic shock; routines for reporting and recording.
2. Slides, filmstrips, films, videotapes, and/or mediated programmed instruction (individual or group) on purpose, procedures, techniques, and routines for treatment of stings or bites by wasp, hornet, bee, scorpion, stingray, saltwater catfish, and jellyfish stings and animal, human, spider and snakes.
3. Hardcover programmed instruction
4. Lecture
5. Discussion

6. Demonstration
7. Study assignments
8. Written exercises

Training Aids

1. Filmstrips/films/videotapes
2. Mediated programmed instruction
3. Hardcover programmed instruction
4. Slides
5. Chalk board
6. Wall charts
7. Anatomical models
8. Equipment and supplies
9. Instructor's guide
10. Student syllabus
11. References

Examination Modes

1. Response in classroom
2. Paper and pencil test
3. Rating on performance in simulated practice
4. Rating on performance in work situation (feedback)
5. Oral quiz on knowledge related to performance in simulated practice and/or work situation (feedback)

Training Time

0:45 hour didactic

0:30 hour supervised practice in conjunction with Learning Module IM24,
"Bites and Stings: Examination of"

LEARNING MODULE IM26

ACUTE HEART CONDITIONS: EXAMINATION OF

Tasks

- 130081 Obtain preliminary medical history, e.g., past/present complaints, allergies, medications
- 130023 Observe for/report symptoms of cardiac arrest
- _____ Observe for/report symptoms of angina pectoris
- _____ Observe for/report symptoms of myocardial infarction
- _____ Observe for/report symptoms of heart block
- 130262 Observe for/report symptoms of acute congestive heart failure
- 110063 Verify identification of patient, e.g., for treatment, medications, examination
- 120080 Inform patient of procedure prior to/during examination/test/treatment
- 120010 Explain/answer patient's questions regarding examination/test/treatment/procedure
- 120091 Explain/answer patient's questions regarding symptoms/disease/treatment
- 150141 Elicit information to ascertain patient's understanding of illness/treatment
- 130436 Evaluate patient's complaints/symptoms of pain
- 120046 Reassure/calm apprehensive/anxious patient
- 130407 Check color of skin, e.g., cyanosis, blanching, jaundice, mottling
- 130110 Perform circulation check, e.g., color, pulse, temperature of skin, capillary return
- 130404 Check/count respirations
- 130014 Check patient's pulse
- 130099 Observe patient for and describe abnormal respirations
- _____ Observe for/report symptoms of abnormal pulse
- 130006 Check blood pressure
- 130636 Observe for/report symptoms of hypotension/hypertension
- 130388 Observe/record or describe characteristics of urine, feces, vomitus, or regurgitation
- 130393 Observe and report level of consciousness
- 130059 Observe for and report symptoms of shock
- 110080 Ground patient, e.g., for electrical cauterization, defibrillation, EKG

- 130003 Apply/change/adjust leads or needle electrodes, e.g., monitor EKG, EEG
- 130087 Identify and describe cardiac arrhythmias which appear on monitor and/or tracing strip
- 130382 Observe/record patient's physical/emotional response to treatment/diagnostic procedure
- 150073 Notify medical personnel of treatment needs of patient
- 150036 Inform doctor/nurse of patient's condition, e.g., description of symptoms, injuries, or response
- 150064 Write nursing notes
- _____ Record on nursing care plan
- 150208 Make entry on SF600 "Chronological Record of Medical Care"

Performance Objective (Stimulus)

When confronted with an individual with an acute heart condition and a physician, nurse, or senior corpsman/technician is not present.

Performance Objective (Behavior)

The corpsman/technician will verify the victim's identity; obtain a brief medical history from the patient, his family and his friends; check the vital signs for abnormalities; observe for symptoms of anxiety, collapse, unconsciousness, and shock; examine for changes in skin color, pupil dilation, nausea with or without vomiting, and the kind and degree of pain, if any. While examining the victim, he will give information to and elicit it from him (if conscious), his family and friends, and reassure them. If electrocardiograph equipment is available, he will do an electrocardiogram. He will observe the victim's response to examination, notify medical personnel of his findings and need for immediate assistance, and record his findings on the appropriate records.

Performance Objective (Conditions)

Without supervision and with or without an assistant, depending on the condition of the victim.

Performance Objective (Criteria)

According to established standard routines, procedures, and techniques.

Performance Objective (Consequence)

A tentative diagnosis will be made for the acute cardiac condition of the patient.

Performance Objective (Next Action)

Give emergency treatment for the acute cardiac condition.

Knowledge and Skills

1. Anatomy and physiology of the heart as related to acute cardiac conditions and the impact of these conditions on other body systems.
2. Observation techniques for assessing acute cardiac conditions:

Angina pectoris--severe gripping pain, oppressive pain in chest which may radiate to neck, jaws, and lower arm; history of indigestion and emotional stress preceding attack; collapse; usually do not lose consciousness; difficult breathing--gasping; ashen gray; clutches chest; apprehensive and will not move for fear of worsening condition.

Acute coronary thrombosis--plugging of cardiac arteries and/or branches; severe agonizing, vice-like pain in chest (may radiate down arm into fourth and fifth fingers, and up into neck and through the back); collapse and loss of consciousness; face ashen pallor; vomiting; and symptoms of severe shock. Gradual rise in temperature may occur following attack.

Acute heart failure--failure of heart muscles to function, causing congestion of blood in lungs and inadequate general circulation. Occurs usually in people with heart disease. Coughing; severe shortness of breath (cannot breathe lying down); and ruddy complexion.

Heart block--failure of nerve impulses that cause heart to beat. No pulse for second or two, difficult breathing, loss of consciousness that results from inadequate blood supply to the brain.

Cardiac arrest--heart has stopped or is beating so rapidly and faintly it cannot maintain circulation; lack of breathing; no pulse at wrist or neck; and enlarged pupils.

3. Communication techniques for giving information to and eliciting information from the patient and for reporting to supervisory personnel.
4. Routine for verification of patient's identity

5. Procedures, techniques, and routines for obtaining vital signs and performing an electrocardiogram and for reporting to medical personnel and recording on appropriate records.

Instructional Strategies

1. Pretest and/or review on anatomy and physiology of heart and relationship to cardiovascular and other body systems; communication and observation skills; routines for identifying victim, reporting and recording; procedures, techniques, and routines for taking vital signs.
2. Slides, filmstrips, films, videotapes, and/or mediated programmed instruction (individual or group) on cause, past history, signs and symptoms of angina pectoris, acute coronary thrombosis, acute heart failure, heart block, and cardiac arrest; procedures, techniques, and routines for taking an electrocardiogram.
3. Hardcover programmed instruction
4. Lecture
5. Discussion
6. Demonstration
7. Practice in simulated patient care unit
8. Study assignments
9. Written exercises
10. Case studies

Training Aids

1. Filmstrips/films/videotapes
2. Mediated programmed instruction
3. Hardcover programmed instruction
4. Slides
5. Wall charts
6. Chalk board
7. Anatomical models
8. Equipment and supplies
9. Instructor's guide
10. Student syllabus
11. References

Examination Modes

1. Response in classroom
2. Paper and pencil test
3. Rating on performance in simulated practice
4. Rating on performance in work situation (feedback)
5. Oral quiz on knowledge related to performance in simulated practice and/or work situation (feedback)
6. Case studies

Training Time

1:00 hour didactic

2:00 hours supervised practice

LEARNING MODULE IM27
ACUTE HEART CONDITIONS: TREATMENT FOR

Tasks

- 150143 Initiate procedure in the absence of a doctor
- 110063 Verify identification of patient, e.g., for treatment, medications, examination
- 120080 Inform patient of procedure prior to/during examination/test/treatment
- 120010 Explain/answer patient's questions regarding examination/test/treatment/procedure
- 150141 Elicit information to ascertain patient's understanding of illness/treatment
- 120091 Explain/answer patient's questions regarding symptoms/disease/treatment
- 130436 Evaluate patient's complaints/symptoms of pain
- 120046 Reassure/calm apprehensive/anxious patient
- 120004 Reinforce patient's positive response to therapy
 - _____ Give emergency treatment/first aid for angina pectoris
 - _____ Give emergency treatment/first aid for myocardial infarction
 - _____ Give emergency treatment/first aid for heart block
 - _____ Give emergency treatment/first aid for acute congestive heart failure
- 140042 Give emergency treatment/first aid for cardiac arrest
- 140072 Give external cardiac massage
 - _____ Loosen tight clothing, e.g., collar, waistband, belt
 - _____ Assist patient/move patient into prone, supine, Sim's, Fowler's position
- 110093 Position patient in body alignment with adequate support
 - _____ Keep victim quiet, warm, and as comfortable as possible
- 140086 Give oxygen therapy, i.e., cannula, catheter, mask
- 150022 Determine need to defibrillate patient
- 110080 Ground patient, e.g., for electrical cauterization, defibrillation, EKG
- 140063 Defibrillate the patient
- 140011 Administer subcutaneous injections
- 140012 Administer sublingual/buccal medications
- 130382 Observe/record patient's physical/emotional response to treatment/diagnostic procedure

- 150069 Give/receive verbal reports about patient
- 150036 Inform doctor/nurse of patient's condition, e.g., description of symptoms, injuries, or response
- 150073 Notify medical personnel of treatment needs of patient
- 150064 Write nursing notes
- 150208 Make entry on SF600 "Chronological Record of Medical Care"

Performance Objective (Stimulus)

When a corpsman/technician has examined a victim and made an emergency diagnosis of an acute cardiac condition.

Performance Objective (Behavior)

The corpsman/technician will continue to communicate with the victim (if conscious) about the procedure being performed, reassure him, and observe his response; position the victim according to his cardiac condition; prevent movement, exertion or strain; give feeling of protection, security, and understanding; loosen tight clothing; administer medications; give oxygen; prevent aspiration in case of vomiting; defibrillate patient if equipment is available; give cardiac massage and mouth to mouth resuscitation.

Performance Objective (Conditions)

Without supervision and with or without an assistant, depending on the condition of the patient.

Performance Objective (Criteria)

According to established standard procedures, techniques, and routines.

Performance Objective (Consequence)

Emergency treatment for a victim of an acute cardiac condition prior to medical treatment.

Performance Objective (Next Action)

Refer victim to physician for further medical care.

Knowledge and Skills

1. Anatomy and physiology of the heart as related to acute cardiac conditions and the impact of these conditions on other body functions.
2. Communication techniques for giving information to and eliciting information from the patient and for reporting to supervisory personnel.
3. Observation techniques for assessing patient's or victim's condition and response to emergency treatment.
4. Patient's emergency diagnosis and condition as related to emergency treatment
5. Procedures, techniques, and routines for emergency treatment of:

Angina pectoris--semi-reclining position with head slightly raised; protect from exertion and emotional strain; give victim feeling of understanding, protection, and security; keep warm and comfortable; move after attack has passed.

Acute coronary thrombosis--half sitting position; give nitroglycerine or amyl nitrate; loosen clothing; give oxygen; allay fears; assist, if necessary, to vomit with minimum effort; avoid further strain on heart; give 1/4 grain morphine; summon medical aid immediately.

Acute heart failure--sitting position; protect and make comfortable; give oxygen; summon medical aid immediately.

Heart block--reclining position; give oxygen; summon immediate medical aid.

Cardiac arrest--give external cardiac massage with mouth to mouth, mouth to nose, or mouth to airway resuscitation.

6. Precautionary measures relative to each type of emergency treatment for each type of acute cardiac condition.

Instructional Strategies

1. Pretest and/or review on anatomy and physiology of the heart and relationship to cardiovascular and other body systems; communication and observation skills; routines for identifying victim, reporting, and recording; procedures, techniques, and routines for mouth to mouth, mouth to nose, and mouth to airway resuscitation; administration of medications; positioning and moving; giving oxygen; preventing exertion and giving feeling of support, protection, and security.
2. Slides, filmstrips, films, videotapes, and/or mediated programmed instruction (individual or group) on procedures, techniques, and routines for emergency treatment for each type of acute cardiac condition.

3. Hardcover programmed instruction
4. Lecture
5. Discussion
6. Demonstration
7. Practice in simulated patient care unit
8. Study assignments
9. Written exercises
10. Case studies

Training Aids

1. Filmstrips/films/videotapes
2. Mediated programmed instruction
3. Hardcover programmed instruction
4. Slides
5. Wall charts
6. Chalk board
7. Anatomical models
8. Equipment and supplies
9. Instructor's guide
10. Student syllabus
11. References

Examination Modes

1. Response in classroom
2. Paper and pencil test
3. Rating on performance in simulated practice
4. Rating on performance in work situation (feedback)
5. Oral quiz on knowledge related to performance in simulated practice and/or work situation (feedback)
6. Case studies

Training Time

- 1:00 hour didactic
- 1:30 hours supervised practice

LEARNING MODULE IM28
MOVING AND TRANSPORTING EMERGENCY CASES

Tasks

- 110067 Accompany ambulance on calls
- 120080 Inform patient of procedure prior to/during examination/test/treatment
- 120010 Explain/answer patient's questions regarding examination/test/treatment/procedure
- 150141 Elicit information to ascertain patient's understanding of illness/treatment
- 120046 Reassure/calm apprehensive/anxious patient
- 120088 Reassure/calm children for examination/treatment
- 120085 Reassure apprehensive parents of pediatric patient
- 130436 Evaluate patient's complaints/symptoms of pain
- 130136 Sort/categorize casualties
- 150161 Determine if patient is transportable
- 150081 Determine priorities for evacuation of patients
- 110134 Identify/mark casualty who has received treatment, e.g., mark with TM
- 150009 Determine method for moving, transporting patients
- 110136 Move casualty using drags or carries
- 110006 Assist patient to stand/walk
- 110086 Assist patients during evacuation procedures
- 110032 Load/unload patients from stretchers (gurney)
- 110135 Transport patient up/down ladders on ship
- 110132 Load/unload patient from ambulance
- 110137 Load/unload patient from helicopter/ship lifts
- 110019 Evacuate casualties
- 150036 Notify doctor/nurse of patient's condition, e.g., description of symptoms, injury, response
- 150073 Notify medical personnel of treatment needs of patient
- 150208 Make entry on SF600 "Chronological Record of Medical Care"

Performance Objective (Stimulus)

When assigned to ambulance call and responding to an emergency at which a physician, nurse, or senior corpsman/technician is not present.

Performance Objective (Behavior)

The corpsman/technician will sort the emergency victims for transport according to the kind and extent of injury in the order of urgency for medical treatments; ascertain that the victims who have received treatment and/or medication are tagged to reflect these; determine how a victim shall be moved and transported; inform the victim (if conscious) and his family or friends about the moving and transporting of the victim to a specific medical facility, ascertain that they understand, and reassure them; move the victim by most appropriate available means and load onto the ambulance, transport to the designated medical facility, and unload at the emergency room. He will transport patients up and down ladders of ships and load and unload them from ship lifts and helicopters. He will notify medical personnel of patient's condition, treatment received and response to it, and record on appropriate records.

Performance Objective (Conditions)

Without supervision and with or without an assistant or technical assistant, depending upon the condition of the patient and the availability of assistance.

Performance Objective (Criteria)

According to established standard procedures, techniques, and routines.

Performance Objective (Consequence)

Patients will be evacuated from emergency site to medical care facility in order of urgency for treatment.

Performance Objective (Next Action)

Replenish and ready ambulance for next call.

Knowledge and Skills

1. Criteria for sorting victims (triage) for moving and transporting in order of kind and extent of injury and urgency for medical care, such as massive hemorrhage, in shock prior to fractures of extremities, not bleeding, and not in shock.

2. Method for moving victim such as stretcher, body carry or drag and assisting to walk, and transporting him up and down stairs and ships' ladders.
3. Loading/unloading victim onto and off ambulance, ship lift, helicopter
4. Positioning patient and emergency treatment enroute to medical care
5. Precautionary measures in handling, moving, and transporting victims
6. Observation techniques for assessing victim's condition and response to emergency treatment.
7. Communication techniques for giving information to and eliciting it from the victim (if conscious), his family and friends; directing assistants in moving and transporting victims; and reporting to medical personnel.

Instructional Strategies

1. Pretest and/or review on anatomy and physiology as related to injury and/or emergency condition; positioning and moving patients with and without assistance; treatment for injury and emergency conditions; observation and communication skills; routines for reporting and recording.
2. Slides, filmstrips, films, videotapes, and/or mediated programmed instruction (individual or group) on criteria for sorting victims for emergency evacuation; procedures, techniques, and routines for moving, positioning, and transporting victims of emergencies with and without assistance, including transporting up and down stairs and ships' ladders and loading onto and unloading from ships' lifts, helicopters, and ambulances.
3. Hardcover programmed instruction
4. Lecture
5. Discussion
6. Demonstration
7. Practice in simulated patient care unit
8. Study assignments
9. Written exercises

Training Aids

1. Filmstrips/films/videotapes
2. Mediated programmed instruction
3. Hardcover programmed instruction
4. Slides

5. Chalk board
6. Anatomical models
7. Equipment and supplies
8. Instructor's guide
9. Student syllabus
10. References

Examination Modes

1. Response in classroom
2. Paper and pencil test
3. Rating on performance in simulated practice
4. Rating on performance in work situation (feedback)
5. Oral quiz on knowledge related to performance in simulated practice and/or work situation (feedback)

Training Time

1:30 hours didactic

1:30 hours supervised practice

TRAINING UNIT IN
SKIN DYSFUNCTIONS: DIAGNOSTIC, THERAPEUTIC, AND
REHABILITATIVE PROCEDURES

Learning Modules

- IN1. Skin Disease: Observation, Examination, and Tentative Diagnosis
- IN2. Skin Specimens: Collecting and Handling Skin Scrape
- IN3. Skin Specimens: Collecting and Handling Skin Biopsy
- IN4. Skin: Decubiti Care
- IN5. Skin: Comedo Sebaceous Material Extraction

Training Objective

Upon completion of this training unit, the learner must be able to observe, report, and record abnormalities in the color, temperature, and texture of the skin; to examine and describe primary and secondary skin lesions and to make tentative diagnosis of infectious skin diseases such as dermatitis, impetigo, and fungus. He must be able to identify communicable diseases' rashes. He must be able to assist with biopsies, to extract sebaceous material from comedos and to obtain and send skin scrape specimens to the laboratory. He must be able to apply topical medications and dressings to decubiti, debride and irrigate decubiti; move patient with decubiti to air mattress and Stryker or Foster frame and to care for him on the frame.

According to the requirements for the treatment or procedure, the learner must be able to verify the doctor's orders and patient's identity; inform the patient about the care, treatment, test, or procedure, answer his questions, and reassure him; determine any contraindications for the care, treatment, test, or procedure and notify the supervisory personnel; collect, check, and prepare the required equipment and supplies; position and drape the patient; wash his hands; give or assist in giving the prescribed care, treatment, test, or procedure; clean the patient and change his linen and clothing if necessary; if indicated, suggest changes in patient care and modify the nursing care plan to reflect the changes; report to his supervisor, as required, the patient's

condition, care, treatment, and test given and procedure performed, the results of it, and the patient's response to it; and record the foregoing information on the nursing notes and check off on the nursing care plan.

He must be able to accomplish the foregoing without supervision or with indirect supervision and with or without an assistant, depending upon the condition of the patient. He must be able to perform the foregoing according to established standard routines, procedures, and techniques.

The patient will receive the required care and the treatments and tests ordered by the physician, and he will be observed and examined for skin diseases and abnormalities.

Knowledge and Skills

1. Purpose of skin scrapes and biopsies, extraction of sebaceous material from comedo; care of decubiti; and observation and examination for skin disease and abnormalities.
2. Anatomy and physiology of the skin and underlying tissue; common skin diseases and abnormalities to be observed and identified; preparation for treatments and obtaining specimens; therapeutic measures for decubitus ulcers and comedo.
3. Communication techniques for giving information to and eliciting it from the patient and for reporting to supervisory personnel.
4. Observation techniques for observing skin dysfunctions, the results of treatments and procedures given to the patient, and the patient's response to treatments or procedures and his condition.
5. Routines for verification of doctor's orders and patient's identity
6. Patient's diagnosis, therapy, and condition as related to observation and examination findings, treatments, and tests.
7. Criteria for contraindication for prescribed treatments or procedures
8. Procedures, techniques, and routines for examining patient's skin for disease and abnormalities; obtaining scrape and biopsy skin specimens; applying topical medication and dressings to decubiti; debriding and irrigating decubiti; placing patient with decubiti on air mattress and Stryker or Foster frames and caring for him; and extracting sebaceous material from comedo.
9. Precautionary measures related to use of turning frames and sterile set-ups or procedures.

10. Routines and techniques for suggesting changes in patient care and modifying nursing care plan to reflect changes.
11. Routines and procedures for clean-up and care of equipment

Instructional Strategies

1. Pretest and/or review on anatomy and physiology of the skin and underlying tissues; characteristics of normal skin; communication and observation skills; routines for verifying doctor's orders and patient's identity; routine for sending specimens to laboratory; isolation technique; application of topical drugs; routine for reporting and recording; routine for changing nursing care plan.
2. Slides, filmstrips, films, videotapes, and/or mediated programmed instruction (individual or group) on purpose, procedures, techniques, and routines for examining the skin for diseases and abnormalities; preparing for and assisting in obtaining or obtaining skin scrape and biopsy specimens; applying topical drugs and dressings to decubiti; debriding and irrigating decubiti; placing patient with decubiti on air mattress or turning frame and caring for him; and extracting sebaceous material from comedo.
3. Hardcover programmed instruction
4. Lecture
5. Discussion
6. Demonstration
7. Practice in simulated patient care unit
8. Practice in work situation
9. Study assignments
10. Written exercises

Training Aids

1. Filmstrips/films/videotapes
2. Mediated programmed instruction
3. Hardcover programmed instruction
4. Slides
5. Wall charts
6. Chalk board
7. Anatomical models
8. Equipment and supplies

9. Instructor's guide
10. Student syllabus
11. References

Examination Modes

1. Response in classroom
2. Paper and pencil test
3. Rating on performance in simulated practice
4. Rating on performance in work situation (feedback)
5. Oral quiz on knowledge related to performance in simulated practice and/or work situation (feedback)

Training Time

- 4:05 hours didactic
- 2:20 hours supervised practice

LEARNING MODULE IN1

SKIN DISEASES: OBSERVATION, EXAMINATION, AND TENTATIVE DIAGNOSIS

Tasks

- _____ Wash hands prior to/after patient care, medications, treatment, examination, procedure, specimen collecting and handling
- 110063 Verify identification of patient, e.g., for treatment, medication, examination
- 130081 Obtain preliminary medical history, e.g., past/present complaints, allergies, medications
- 120080 Inform patient of procedure prior to/during examination/test/treatment
- 120010 Explain/answer patient's questions regarding examination/test/treatment/procedure
- 120046 Reassure/calm apprehensive/anxious patient
- 120088 Reassure/calm children for examination/treatment
- 120085 Reassure apprehensive parents of pediatric patient
- 130436 Evaluate patient's complaints/symptoms of pain
- 130239 Check skin turgor (elasticity)
- 130407 Check color of skin, e.g., cyanosis, blanching, jaundice, mottling
- 130408 Check texture of the skin, e.g., dry, oily, scaly
- 130409 Check temperature of the skin
- 130013 Check skin for abnormal conditions, e.g., pressure sores, bruises, needle marks
- 130365 Examine for/report symptoms of cellulitis
- 130483 Examine for symptoms of contact dermatitis
- 130484 Examine for symptoms of atopic dermatitis
- 130485 Examine and describe characteristics of hives and rashes
- 138021 Make preliminary diagnosis of impetigo
- _____ Make preliminary diagnosis of rubella, rubeola, varicella, smallpox, scarlet fever
- 130022 Examine for symptoms of external fungus infections; ringworm
- 130486 Examine for viral infections of the skin, e.g., warts
- 130066 Screen and isolate patient with suspected communicable disease
- 150036 Inform doctor/nurse of patient's condition, e.g., description of symptoms, injuries, or response

150013 Make suggestions regarding patient care

150064 Write nursing notes

_____ Record on patient's record

Performance Objective (Stimulus)

When a patient complains about skin abnormalities or presents himself for skin examination or when directed by the senior corpsman/technician, nurse, or doctor to examine the patient's skin for symptoms of disease.

Performance Objective (Behavior)

The corpsman/technician will wash his hands prior to and following the examination; verify the patient's identity; communicate with the patient, or his family in case of a child, about the skin problem, such as onset, duration, probable source of problem, complaints, and any treatment administered; inspect the entire skin and examine skin over various body areas in detail; look for signs of generalized disease such as temperature, pallor, cyanosis, jaundice, or metabolic discoloration; examine for changes in skin, localize and characterize these changes; make tentative diagnosis; institute isolation if indicated; inform the doctor, nurse, or supervisory technician about the patient's skin condition and describe it and make suggestions regarding care; and record examination findings and given care.

Performance Objective (Conditions)

With indirect supervision and with or without assistance, depending upon the patient's condition and cooperativeness (in the case of a child).

Performance Objective (Criteria)

In accordance with established standard examination procedure using good observation techniques and required precautionary measures for suspect skin conditions.

Performance Objective (Consequence)

Preliminary integument examination with tentative diagnosis.

Performance Objective (Next Action)

Assist doctor, nurse, supervisory technician with examination; or institute care in the absence of doctor, nurse, or senior corpsman/technician.

Knowledge and Skills

1. Purpose of observation, examination, and tentative diagnosis
2. Anatomy and physiology of the skin and characteristics of a normal skin
3. Verification of patient's identity
4. Communication techniques to allay anxiety and apprehension and to elicit information about onset, duration, probable source of problems, complaints, and any treatment administered.
5. Observation of (1) general condition of skin--color, temperature, texture, and turgor; (2) signs of generalized disease--such as pallor, cyanosis, jaundice or metallic discoloration; (3) changes in skin color--local redness, hyperpigmentation, depigmentation, purple striae, melanoma; examination for isolated lesions, multiple lesions, and their pattern of distribution and lesions universally distributed over the body; description of characteristics of primary skin lesions--macule, papule, nodule, tumor, vesicle, and bulla; and of secondary lesions--scale, exudate, ulcer, hyperpigmentation, signs of excoriation, and signs of healing.
6. Making tentative diagnosis for contact or atopic dermatitis, impetigo, rubella, rubeola, varicella, smallpox, scarlet fever, ringworm and other common fungus infections, warts and other viral infections, cellulitis, decubiti, bruises, and needle marks.
7. Routine for isolation precautions, if indicated
8. Routine for reporting to doctor, nurse, or supervising technician
9. Routine for recording on patient's record and/or nursing notes

Instructional Strategies

1. Pretest and/or review on anatomy and physiology of the skin; characteristics of normal skin; communication and observation skills; isolation technique.
2. Slides, filmstrips, films, videotapes, and/or mediated programmed instruction (individual or group) on general conditions of skin, changes in condition of skin and causative factors, identification of primary and secondary skin lesions, tentative diagnosis of contact and atopic dermatitis, insect and vermin bites, animal and human bites, impetigo, rubella, rubeola, chickenpox, smallpox, scarlet fever, ringworm, and other fungus infections, warts and other viral infections, decubiti, cellulitis, bruises, needle marks.

3. Hardcover programmed instruction
4. Lecture
5. Discussion
6. Study assignments
7. Written exercises
8. Case studies

Training Aids

1. Filmstrips/films/videotapes
2. Mediated programmed instruction
3. Hardcover programmed instruction
4. Slides
5. Wall charts
6. Chalk board
7. Equipment and supplies
8. Instructor's guide
9. Student syllabus
10. References

Examination Modes

1. Response in classroom
2. Paper and pencil test
3. Rating on performance in simulated practice
4. Rating on performance in work situation (feedback)
5. Oral quiz on knowledge related to performance in simulated practice and/or work situation (feedback)

Training Time

2:00 hours didactic

LEARNING MODULE IN2

SKIN SPECIMENS: COLLECTING AND HANDLING SKIN SCRAPE

Tasks

- 150137 Ensure that doctor's orders are carried out
- 110063 Verify identification of patient, e.g., for treatment, medications, examination
- 120080 Inform patient of procedure prior to/during examination/test/treatment
- 120010 Explain/answer patient's questions regarding examination/test/treatment/procedure
- 150078 Ask patient/check chart for contraindication to procedure, treatment, test
- 320327 Witness/ensure patient's consent/permission has been obtained for treatment/examination/release
- _____ Wash hands prior to and after patient care, medication, treatment, examination, procedure, specimen collecting and handling
- 110081 Position/hold patient for examination, treatment, surgery
- 259001 Take skin scrape specimen from patient
- _____ Prepare, label, and send specimen to laboratory
- 320015 Assess completeness of lab report
- 130436 Evaluate patient's complaints or symptoms of pain
- 130382 Observe/record patient's physical/emotional response to treatment/diagnostic procedure
- 150064 Write nursing notes
- _____ Record on patient's record

Performance Objective (Stimulus)

When assigned by the senior corpsman/technician, nurse, or doctor to obtain a skin scrape specimen and send it to the laboratory.

Performance Objective (Behavior)

The corpsman/technician will verify the doctor's orders and patient's identity; explain the procedure to the patient and obtain his permission for the procedure; wash hands; position the patient; scrape the skin area with a tongue blade or surgical knife and place the obtained scrapings in a container with

the proper solution; label the specimen and send to the laboratory with the required laboratory request; evaluate the patient's reaction to the procedure and record on the patient's record and nursing care plan.

Performance Objective (Conditions)

With indirect supervision and with or without assistance, depending upon the patient's condition.

Performance Objective (Criteria)

In accordance with established standard procedures, techniques, and routines for taking and sending the skin scrape specimen to laboratory.

Performance Objective (Consequence)

Skin scrape specimen correctly prepared, labeled, and sent to the laboratory.

Performance Objective (Next Action)

Follow-up on return of laboratory reports.

Knowledge and Skills

1. Purpose of scrape specimen
2. Anatomy and physiology of integument
3. Required equipment and supplies
4. Routine for verification of doctor's orders and patient's identity
5. Communicating with the patient about procedure and permission for the procedure
5. Purpose, procedure, and technique for hand washing
6. Preparation for and obtaining of skin scrape specimen, preparation, labeling, and sending specimen to the laboratory; and recording on patient's record.
7. Routine for equipment care following use

Instructional Strategies

1. Pretest and/or review on anatomy and physiology of the skin; routines for verifying doctor's orders and patient's identity; communication and observation skills; routine and procedure for labeling and sending specimens to the laboratory; routines for recording and reporting.

2. Slides, filmstrips, films, videotapes, and/or mediated programmed instruction (individual or group) on procedures and techniques for taking and preparing a skin scrape specimen for the laboratory.
3. Discussion
4. Demonstration
5. Practice in simulated patient care unit
6. Practice in work situation
7. Study assignments

Training Aids

1. Filmstrips/films/videotapes
2. Mediated programmed instruction
3. Hardcover programmed instruction
4. Slides
5. Chalk board
6. Equipment and supplies
7. Anatomical models
8. Instructor's guide
9. Student syllabus
10. References

Examination Modes

1. Response in classroom
2. Paper and pencil test
3. Rating on performance in simulated practice
4. Rating on performance in work situation (feedback)
5. Oral quiz on knowledge related to performance in simulated practice and/or work situation (feedback)

Training Time

- 0:15 hour didactic
- 0:20 hour supervised practice

LEARNING MODULE IN3
SKIN SPECIMENS: COLLECTING AND HANDLING SKIN BIOPSY

Tasks

- 150137 Ensure that doctor's orders are carried out
- 110063 Verify identification of patient, e.g., for treatment/medication
- 120080 Inform patient of procedure prior to/during examination/test/treatment
- 120010 Explain/answer patient's questions regarding examination/test/treatment/procedure
- 150078 Ask patient/check chart for contraindication to procedure, treatment, test
- 320327 Witness/ensure patient's consent/permission has been obtained for treatment/examination/release
- _____ Wash hands prior to and after patient care, medication, treatment, examination, procedure, specimen collecting and handling
- 145019 Obtain equipment, medications, instruments prn for personnel performing sterile procedure
- 110043 Prepare skin site with antiseptic solution prior to medical examination/treatment
- 110044 Shave and scrub patient for surgery or delivery room or treatment or examination
- 110025 Give phisohex/betadine scrub to patient
- 140243 Apply topical anesthesia
- 145043 Hold vials/ampules of drugs for use and verification during sterile procedure
- 145039 Pour sterile solutions
- 145038 Pass sterile materials, equipment, and medication to personnel performing sterile procedure
- 110081 Position/hold patient for examination, treatment, surgery
- 320015 Assess completeness of lab report
- 259002 Prepare, label, send biopsy specimens to laboratory
- 130436 Evaluate patient's complaints or symptoms of pain
- 130382 Observe/record patient's physical/emotional response to treatment/diagnostic procedure
- 150064 Write nursing notes
- _____ Record on patient's record

Performance Objective (Stimulus)

When assigned by senior corpsman/technician, nurse, or doctor to assist in the taking of a skin biopsy specimen ordered by the physician.

Performance Objective (Behavior)

The corpsman/technician will verify the doctor's orders and the patient's identification; explain the procedure to the patient and ensure that written permission is obtained; check for any contraindications; wash his hands; obtain the necessary sterile instruments, supplies, and medications and set up for the procedure; position and/or hold the patient; verify and pour drugs and pass sterile instruments and supplies to the doctor; prepare, label and send the biopsy specimen to the laboratory with required laboratory report; record procedure and specimens sent to laboratory on the patient's record; and clean up after procedure.

Performance Objective (Conditions)

Without supervision or assistance unless patient's condition warrants an assistant.

Performance Objective (Criteria)

In accordance with established standard procedures, techniques, and routines for ascertaining that sterile technique is used in specimen collection.

Performance Objective (Consequence)

Skin biopsy specimen correctly prepared, labeled, and sent to the laboratory.

Performance Objective (Next Action)

Follow-up to ensure return of laboratory report on biopsy.

Knowledge and Skills

1. Purpose of the skin biopsy
2. Anatomy and physiology of the skin
3. Communication techniques for giving information to and eliciting it from the patient and reporting to supervisory personnel.

4. Observation techniques for assessing patient's condition and response to biopsy and maintenance of sterile technique during the procedure.
5. Routine for verification of doctor's orders and patient's identity
6. Routine for obtaining patient's permission for procedure
7. Sterile technique for minor surgery
8. Patient's diagnosis, therapy, and condition as related to procedure
9. Criteria for determining contraindications for biopsy
10. Procedure, technique, and routine for hand washing
11. Procedures, techniques, and routines for setting up, assisting doctor with biopsy, preparing and sending specimen to the laboratory.
12. Precautionary measures relative to biopsy procedure
13. Routine for equipment care following use and clean up

Instructional Strategies

1. Pretest and/or review on anatomy and physiology of integument; routines for verifying doctor's orders and patient's identity; communication and observation skills; routine for labeling and sending specimens to laboratory; routines for recording and reporting.
2. Slides, filmstrips, films, videotapes, and/or mediated programmed instruction (individual or group) on procedure, techniques, and routines for preparing for and assisting the physician with skin biopsy.
3. Discussion
4. Demonstration
5. Practice in simulated patient care unit
6. Practice in work situation
7. Study assignments

Training Aids

1. Filmstrips/films/videotapes
2. Mediated programmed instruction
3. Slides
4. Chalk board
5. Equipment and supplies
6. Instructor's guide
7. Student syllabus
8. References

Examination Modes

1. Response in classroom
2. Paper and pencil test
3. Rating on performance in simulated practice
4. Rating on performance in work situation (feedback)
5. Oral quiz on knowledge related to performance in simulated practice and/or work situation (feedback)

Training Time

0:30 hour didactic

0:30 hour supervised practice

LEARNING MODULE IN4
SKIN: DECUBITI CARE

Tasks

- 320328 Cross check medication and treatment card with KARDEX and doctor's orders
- _____ Wash hands prior to/after patient care, medication, treatment, examination, procedure, specimen collecting and handling
- 110063 Verify identification of patient, e.g., for treatment, medication, examination
- 120080 Inform patient of procedure prior to/during examination/test/treatment
- 120010 Explain/answer patient's questions regarding examination/test/treatment/procedure
- 150078 Ask patient/check chart for contraindications for treatment/procedure/test
- 130436 Evaluate patient's complaints/symptoms of pain
- 120046 Reassure/calm apprehensive/anxious patient
- 140373 Give special skin/decubiti care, e.g., apply medication, dressings, irrigate
- 140062 Debride wound
- 110096 Change patient's soiled linen and clothing
- 250025 Read equipment manuals for operation and maintenance of equipment
- _____ Move patient onto an air mattress
- 110076 Turn patient on Stryker frame
- 150046 Arrange room/unit for individual patient's needs, e.g., blind, bedridden, post operative
- 130382 Observe/record patient's physical/emotional response to treatment/diagnostic procedure
- 150035 Give report on changes/special care/treatment/tests for patient
- 150013 Make suggestion regarding patient care
- 150082 Suggest changes in nursing care plan for patient
- 150102 Initiate and implement changes in patient's nursing care plan
- 150085 Modify patient care plan according to patient's response and needs, e.g., physical activity
- 150064 Write nursing notes
- _____ Record on nursing care plan

Performance Objective (Stimulus)

When assigned by the senior corpsman/technician, nurse, or doctor to administer care ordered by the physician for a patient's decubiti.

Performance Objective (Behavior)

The corpsman/technician will verify the doctor's orders and the patient's identity; communicate with the patient and answer his questions about the procedure; determine if there are any contraindications to the procedure and if not reassure the patient and apply medications and/or dressing; irrigate the decubiti; debride decubiti; place the patient on an air mattress or a Stryker or Foster frame (turning frame) and give care to him; make suggestions for changes in patient care; assess the patient's reaction to the treatment; report the patient's condition to supervisory personnel; if indicated make suggestions for care and modify patient care plan accordingly; and record on nursing notes and nursing care plan.

Performance Objective (Conditions)

With indirect supervision and without assistance except for turning frames, when technical assistance is required.

Performance Objective (Criteria)

In accordance with established routine and standard procedure.

Performance Objective (Consequence)

Patient's decubiti are treated as prescribed by the physician.

Performance Objective (Next Action)

Check on patient's condition and comfort.

Knowledge and Skills

1. Purpose of medications, dressings, irrigations, debridement, and the use of an air mattress or turning frames in treatment of decubiti.
2. Anatomy and physiology of the skin and underlying tissues
3. Commonly used drugs for decubiti

4. Communication techniques for giving information to and eliciting it from the patient and for reporting to supervisory personnel.
5. Observation techniques for assessing the patient's condition and response to treatment
6. Routine for verification of doctor's orders and patient's identity
7. Patient's diagnosis, therapy, and condition as related to medication, treatments and placing him on an air mattress or Stryker frame or Foster frame.
8. Criteria for determining contraindications for medications, treatments, and the use of an air mattress, Stryker frame or Foster frame.
9. Procedure, techniques, and routines for applying medications and/or dressings and giving irrigations for decubiti; debriding the ulcer; placing the patient on an air mattress (alternating pressure pad) or on a turning frame (Stryker or Foster) and giving care to him on these; and recording treatment or procedure on nursing notes and nursing care plan.
10. Precautionary measures relative to the treatments and use of air mattress and turning frames.
11. Routine for equipment care following use

Instructional Strategies

1. Pretest and/or review on anatomy and physiology of skin and underlying tissues; common topical drugs; communication and observation skills; routines for verification of doctor's orders and patient's identity; procedures and techniques for suggesting patient care changes and modifying patient care plan; recording on nursing notes and nursing care plan and reporting.
2. Slides, filmstrips, films, videotapes, and/or mediated programmed instruction (individual or group) on procedures and techniques for applying medications and dressing to decubiti, irrigating decubiti, debriding decubiti; and placing patient on an air mattress and on turning frame and caring for him on these.
3. Hardcover programmed instruction
4. Lecture
5. Discussion
6. Demonstration
7. Practice in simulated patient care unit
8. Practice in work situation
9. Study assignments
10. Written exercises

Training Aids

1. Filmstrips/films/videotapes
2. Mediated programmed instruction
3. Hardcover programmed instruction
4. Slides
5. Wall charts
6. Chalk board
7. Anatomical models
8. Equipment and supplies
9. Instructor's guide
10. Student syllabus
11. References

Examination Modes

1. Response in classroom
2. Paper and pencil test
3. Rating on performance in simulated practice
4. Rating on performance in work situation (feedback)
5. Oral quiz on knowledge related to performance in simulated practice and/or work situation (feedback)

Training Time

- 1:00 hour didactic
- 1:00 hour supervised practice

LEARNING MODULE IN5
SKIN: COMEDO SEBACEOUS MATERIAL EXTRACTION

Tasks

- 320328 Cross check medication and treatment care with KARDEX and doctor's orders
- _____ Wash hands prior to/after patient care, medication, treatment, examination, procedure, specimen collecting and handling
- 110063 Verify identification of patient, e.g., for treatment, medication, examination
- 120080 Inform patient of procedure prior to/during examination/test/treatment
- 120010 Explain/answer patient's questions regarding examination/test/treatment/procedure
- 150078 Ask patient/check chart for contraindications for treatment/procedure/test
- 130436 Evaluate patient's complaints/symptoms of pain
- 120046 Reassure/calm apprehensive/anxious patient
- 145019 Obtain equipment, medications, instruments prn for personnel performing sterile procedure
- 110025 Give phisohex/betadine scrub to patient
- 110043 Prepare skin site with antiseptic solution prior to medical examination/treatment
- 110081 Position/hold patient for examination, treatment, surgery
- 140270 Extract sebaceous material from comedo
- 140062 Debride wound
- 130382 Observe/record patient's physical/emotional response to treatment/diagnostic procedure
- 150035 Give report on changes/special care/treatment/tests for patient
- 150013 Make suggestion regarding patient care
- 150082 Suggest changes in nursing care plan for patient
- 150102 Initiate and implement changes in patient's nursing care plan
- 150085 Modify patient care plan according to patient's response and needs, e.g., physical activity
- 150064 Write nursing notes
- _____ Record on nursing care plan

Performance Objective (Stimulus)

When assigned by the senior corpsman/technician, nurse, or doctor to extract sebaceous material from comedo as ordered by the doctor.

Performance Objective (Behavior)

The corpsman/technician will verify the doctor's orders and the patient's identity; communicate with the patient and answer his questions about the procedure; determine if there are any contraindications to the procedure and if not reassure the patient; prepare for and remove the sebaceous material from the comedo; assess patient's reaction to treatment; if indicated report to supervisory personnel results of treatment and make suggestions for change in care; modify nursing plan if indicated; and record on nursing notes and nursing care plan.

Performance Objective (Conditions)

With indirect supervision and without assistance.

Performance Objective (Criteria)

According to established standard procedures, techniques, and routines.

Performance Objective (Consequence)

Patient will have blackheads treated as prescribed by the physician.

Performance Objective (Next Action)

Follow-up observation for any untoward reaction such as infection.

Knowledge and Skills

1. Purpose of treatment
2. Anatomy and physiology of the skin and underlying tissue
3. Communication techniques for giving information to and eliciting it from the patient and for reporting to supervisory personnel.
4. Observation techniques for assessing the patient's condition and response to the treatment.

5. Routine for verification of doctor's orders and patient's identity
6. Patient's diagnosis, therapy, and condition as related to the treatment
7. Criteria for determining contraindications for the treatment
8. Procedure, techniques, and routines for washing hands
9. Procedure, techniques, and routines for setting up, preparing the skin area, and extracting sebaceous material from comedo and for recording treatment on nursing notes and nursing care plan.
10. Precautionary measures relative to the treatment
11. Procedures and techniques for suggesting changes in patient care and modifying nursing care plan.

Instructional Strategies

1. Pretest and/or review on anatomy and physiology of skin and underlying tissues; communication and observation skills; routines for verification of doctor's orders and patient's identity; routine for suggesting changes in patient care and modifying nursing care plan to reflect the changes; and routine for recording on nursing notes and nursing care plan.
2. Slides, filmstrips, films, videotapes, and/or mediated programmed instruction (individual or group) on procedures, techniques, and routines for setting up, preparing the skin area, and extracting sebaceous materials from comedo.
3. Hardcover programmed instruction
4. Lecture
5. Discussion
6. Demonstration
7. Practice in simulated patient care unit
8. Practice in work situation
9. Study assignments
10. Written exercises

Training Aids

1. Filmstrips/films/videotapes
2. Mediated programmed instruction
3. Hardcover programmed instruction
4. Slides
5. Chalk board

6. Anatomical models
7. Equipment and supplies
8. Instructor's guide
9. Student syllabus
10. References

Examination Modes

1. Response in classroom
2. Paper and pencil test
3. Rating on performance in simulated practice
4. Rating on performance in work situation (feedback)
5. Oral quiz on knowledge related to performance in simulated practice and/or work situation (feedback)

Training Time

- 0:20 hour didactic
- 0:30 hour supervised practice

TRAINING UNIT IO
RESPIRATORY DYSFUNCTIONS: DIAGNOSTIC, THERAPEUTIC AND
REHABILITATIVE PROCEDURES

Learning Modules

- IO1. Respiratory: Observation of Abnormal Functions and Symptoms of Disease
- IO2. Throat Irrigations and Gargles: Administration of
- IO3. Oxygen, Carbon Dioxide, and Humidity Therapy
- IO4. Intermittent Positive Pressure Breathing Therapy
- IO5. Upper Respiratory Tract: Suctioning of
- IO6. Chest Physical Therapy
- IO7. Tracheotomy Care

Training Objective

Upon completion of this training unit, the learner must be able to observe, report, and record abnormal respirations and symptoms of head colds and sinus blockage; describe sputum; administer throat irrigations and gargles; position patients with difficult breathing; teach deep breathing, coughing, and postural drainage exercises; teach diaphragmatic, unilateral basilar restrictive, and bilateral basilar chest expansion exercises; give oxygen by cannula, catheter, mask, face and body tents, croupette, and tracheotomy tube; administer carbon dioxide; give steam mist treatments; administer intermittent positive pressure breathing therapy; suction nasal and oral passages and trachea; give chest physical therapy; give tracheotomy tube care and deep lung inflation using oxygen and ventilating bag or ventilators; change tracheostomy dressing; maintain and operate automatic and thermatic Gomco, Stedman, and Chaffin Pratt suction machines, oxygen equipment and ventilating bags, ventilators such as Bird, Airshield, MA-1, Emerson, and Bennett PR1 and PR2 and positive pressure breathing units such as Bennett.

According to the requirements for the treatment or procedure, the learner must be able to verify the doctor's orders and patient's identity; inform the patient about the treatment and/or procedure, answer his questions and reassure

him; determine any contraindications for the treatment or procedure and notify supervisory personnel; collect, check, and prepare the required equipment and supplies; position and drape the patient; wash or scrub hands; administer the prescribed treatment, test, examination, and/or procedure; clean the patient and change his linen and/or clothing, if necessary; if indicated suggest changes in the patient care and modify the nursing care plan to reflect the changes; report to his supervisor as required the patient's condition, treatment given and/or procedure performed, the results of it and the patient's response to it; and record the foregoing information on the nursing notes and check off on the nursing care plan.

The learner must be able to accomplish the foregoing with indirect and selective supervision or without supervision and with or without an assistant, depending upon the condition of the patient. He must be able to perform the foregoing in accordance with established standard procedures, techniques, and routines using precautionary and safety measures when handling gases and electrical equipment.

The patient will receive the care, treatments, examinations, and procedures prescribed by the doctor and will be observed for respiratory dysfunctions.

Knowledge and Skills

1. Purpose of observations for respiratory abnormalities and disease; throat irrigations and gargles; oxygen, carbon dioxide, and humidity therapy; intermittent positive pressure breathing therapy; chest physical therapy; suctioning of upper respiratory tract and tracheotomy care.
2. Anatomy and physiology of respiratory and related systems
3. Communication techniques for giving information to and eliciting information from the patient and for reporting to supervisory personnel.
4. Observation techniques for observing the signs and symptoms of respiratory dysfunctions; the results of care, treatments, and procedures given to the patient, the result of these, and the patient's response to them.
5. Routine for verification of doctor's orders and patient's identity
6. Patient's diagnosis, therapy, and condition as related to respiratory dysfunctions; throat irrigations and gargles; oxygen, carbon dioxide, and humidity therapy; intermittent positive pressure breathing therapy; chest physical therapy; suctioning of the upper respiratory tract; and tracheotomy care.

7. Criteria for contraindications for prescribed care, treatments, and procedures of the respiratory tract.
8. Procedures, techniques, and routines for observing respiratory dysfunctions; giving throat irrigations and gargles; administering oxygen, carbon dioxide, and humidity therapy; giving intermittent positive pressure breathing therapy; giving chest physical therapy; suctioning nasal and oral passages and trachea and giving tracheotomy care.
9. Precautionary measures relative to administering oxygen and carbon dioxide; use of electrical equipment; suctioning trachea; and providing tracheotomy care.
10. Routines and techniques for suggesting changes in patient care and for modifying nursing care plan to reflect changes.
11. Routines and procedures for clean up and care of equipment

Instructional Strategies

1. Pretest and/or review on anatomy and physiology of respiratory and circulatory systems; communication, observation, and instructional skills; routines for verifying doctor's orders and patient's identity; respiration count and abnormalities; positioning the patient to facilitate breathing; routine, procedures, and techniques for hand wash and scrub; routines for reporting and recording.
2. Slides, filmstrips, films, videotapes, and/or mediated programmed instruction (individual or group) on purpose, procedures, techniques, and routines for throat irrigations and gargles; administering oxygen by cannula, catheter, mask, face and body tents, croupette, and tracheotomy tube; administering carbon dioxide; giving steam mist treatments; administering intermittent positive pressure breathing; giving chest physical therapy and postural drainage; giving tracheotomy tube care and deep lung inflation using oxygen and ventilating bag and ventilators; changing tracheostomy dressing; teaching deep breathing, coughing and diaphragmatic, unilateral basilar restrictive, and bilateral basilar chest expansion exercises; and maintenance and operation of suction, ventilators, and other equipment required for foregoing treatments and procedures.
3. Hardcover programmed instruction
4. Lecture
5. Discussion
6. Demonstration
7. Practice in simulated patient care unit
8. Practice in work situation
9. Study assignments
10. Written exercises

Training Aids

1. Filmstrips/films/videotapes
2. Mediated programmed instruction
3. Hardcover programmed instruction
4. Slides
5. Wall charts
6. Chalk board
7. Anatomical models
8. Equipment and supplies
9. Instructor's guide
10. Student syllabus
11. References

Examination Modes

1. Response in classroom
2. Paper and pencil test
3. Rating on performance in simulated practice
4. Rating on performance in work situation (feedback)
5. Oral quiz on knowledge related to performance in simulated practice and/or work situation (feedback)

Training Time

4:15 hours didactic

5:30 hours supervised practice

LEARNING MODULE IO1

RESPIRATORY: OBSERVATION FOR ABNORMAL FUNCTIONS AND SYMPTOMS OF DISEASE

Tasks

- 130404 Check/count respirations
- 130099 Observe patient for/report and describe abnormal respirations
- 130405 Observe for/report characteristics of cough
- 130425 Observe/record or describe characteristics of sputum, mucus
- 130040 Observe for/report symptoms of head colds
- 130062 Observe for/report symptoms of sinus blockage
- 130436 Evaluate patient's complaints/symptoms of pain
- 150063 Talk with patient to ascertain needs/problems
- 120046 Reassure/calm apprehensive/anxious patient
- 110063 Verify identification of patient, e.g., for treatment, medications, examination
- 150036 Inform doctor/nurse of patient's condition, e.g., description of symptoms, injuries or response
- 150073 Notify medical personnel of treatment needs of patient
- 150082 Suggest changes in nursing care plan for patient
- 150102 Initiate and implement change in patient care plan
- 150064 Write nursing notes

Performance Objective (Stimulus)

When making patient rounds and when taking care of a patient.

Performance Objective (Behavior)

The corpsman/technician will observe abnormalities in respiratory functions by assessing the rate, rhythm, and type of respirations; recognize the presence of a cough, the kind of cough and its productivity, and the amount and kind of sputum raised; recognize the symptoms of a cold and sinus blockage; determine the presence of pain and the kind of pain associated with upper respiratory difficulties; identify the patient's problems and needs; inform the supervisory personnel about his findings; make suggestions for changes in the nursing care plan and modify it to reflect the changes; and record his observations and findings on the nursing notes.

Performance Objective (Conditions)

Without supervision or assistance.

Performance Objective (Criteria)

Using good observation techniques and reporting and recording according to established standard procedures, techniques, and routines.

Performance Objective (Consequence)

Abnormalities of the patient's respiratory functions and symptoms of respiratory disease will be observed, reported, and recorded.

Performance Objective (Next Action)

Give prescribed treatment.

Knowledge and Skills

1. Anatomy and physiology of respiratory system and normal respirations
2. Coughs--causes, frequency, type, productive or dry and significance as related to patient's diagnosis, therapy, treatment, and condition.
3. Sputum--causes, amount, kind, presence of blood and significance as related to patient's diagnosis, therapy, treatment, and condition.
4. Head colds--cause, signs and symptoms, and significance
5. Sinus blockage--cause, signs and symptoms and significance
6. Routine for verification of patient's identity
7. Communication techniques for eliciting information from and giving it to the patient, reassuring him and reporting to supervisory personnel.
8. Observation techniques for assessing patient's respiratory functions and symptoms of disease.
9. Routines and techniques for suggesting changes in patient care and for modifying nursing care plan to reflect changes.
10. Routine and procedure for recording findings on nursing notes

Instructional Strategies

1. Pretest and/or review on anatomy and physiology of respiratory system; observation and communication skills; procedure and techniques for counting respirations and observing for abnormalities; routines for reporting and recording.

2. Slides, filmstrips, films, videotapes, and/or mediated programmed instruction (individual or group) on signs and symptoms of head colds and sinus blockage; coughing--cause, frequency, type, productive or not; sputum--amount and description; and significance of these conditions.
3. Hardcover programmed instruction
4. Lecture
5. Discussion
6. Demonstration
7. Practice in simulated patient care unit
8. Practice in work situation
9. Study assignments
10. Case studies

Training Aids

1. Filmstrips/films/videotapes
2. Mediated programmed instruction
3. Hardcover programmed instruction
4. Slides
5. Wall charts
6. Chalk board
7. Instructor's guide
8. Student syllabus
9. References

Examination Modes

1. Response in classroom
2. Paper and pencil test
3. Rating on performance in simulated practice
4. Rating on performance in work situation (feedback)
5. Oral quiz on knowledge related to performance in simulated practice and/or work situation (feedback)

Training Time

- 0:30 hour didactic
- 0:30 hour supervised practice

AD-A085 706

TECHNOMICS INC OAKTON VA

A SYSTEM APPROACH TO NAVY MEDICAL EDUCATION AND TRAINING. APPEN--ETC(11)

F/G 5/9

AUG 74

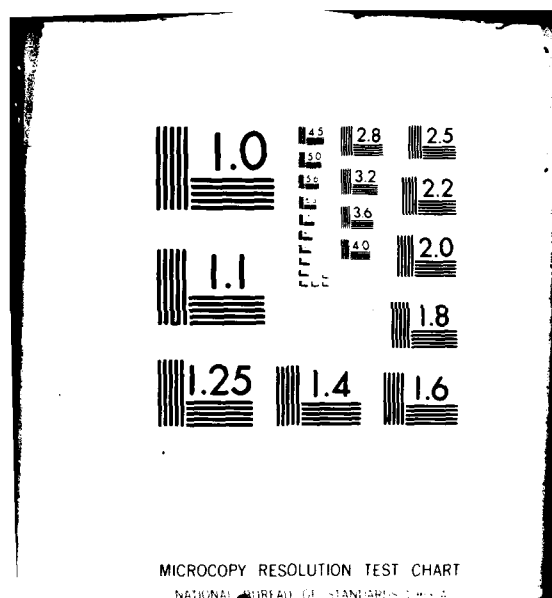
N00014-69-C-0246

NL

UNCLASSIFIED

6 of 7

AD-A085 706



LEARNING MODULE 102
THROAT IRRIGATIONS AND GARGLES: ADMINISTRATION OF

Tasks

- 320328 Cross check medication and treatment cards with KARDEX and doctor's orders
- 110063 Verify identification of patient, e.g., for treatment, medications, examination
- 120080 Inform patient of procedures required prior to/during examination/test/treatment
- 150078 Ask patient/check chart for contraindication for treatment/procedure/test
- 120010 Explain/answer patient's questions regarding examination/test/treatment/procedures
- 120046 Reassure/calm apprehensive/anxious patient
- 130436 Evaluate patient's complaints/symptoms of pain
- _____ Wash hands prior to/after patient care, medications, treatments, examination, procedures, collecting and handling specimens
- 140094 Give throat irrigation/gargle
- 130382 Observe/record patient's physical/emotional response to treatment/diagnostic procedures
- 150069 Give/receive verbal reports about patient
- 150035 Give report on changes/special care/treatments/tests for patient
- 150013 Make suggestion regarding patient care, e.g., need of medication, treatment
- 150082 Suggest changes in nursing care plan for patient
- 150102 Initiate and implement change in patient care plan
- 150064 Write nursing notes

Performance Objective (Stimulus)

When assigned by the physician, nurse, or senior corpsman/technician to give a throat irrigation ordered by the physician.

Performance Objective (Behavior)

The corpsman/technician will check for due orders or the need for prn orders; verify the orders and the patient's identity; inform the patient about the

treatment and allay any apprehensions of the patient about the treatment; check for any contraindications for the treatment; wash his hands; collect the required equipment and administer the throat irrigations and gargles; report to supervisory personnel completion of treatment, results of treatment, patient's response to treatment and his condition, and record on nursing notes; and, if indicated, suggest changes in patient care and modify nursing care plan to reflect the changes.

Performance Objective (Conditions)

Without supervision or assistance.

Performance Objective (Criteria)

In accordance with established standard procedures, techniques, and routines.

Performance Objective (Consequence)

Patient will receive prescribed throat irrigation or gargle.

Performance Objective (Next Action)

Make patient as comfortable as possible, clean up after treatment, and care for equipment.

Knowledge and Skills

1. Purpose of throat irrigation or gargle
2. Anatomy and physiology of mouth and nasopharynx
3. Communication techniques for giving information to the patient and for eliciting it from him and for reporting to supervisory personnel.
4. Observation techniques for evaluating the patient's condition and response to the treatment.
5. Routine for verifying doctor's orders and patient's identity
6. Patient's diagnosis, therapy, and condition as related to giving throat irrigation or gargle
7. Contraindications for giving throat irrigation or gargle
8. Procedures, techniques, and routines for administering throat irrigation and gargle

9. Precautionary measures relative to throat irrigation for patients with mouth and throat impairment.
10. Routines and techniques for suggesting changes in patient care and for modifying nursing care plan to reflect changes.
11. Routines and procedures for clean up and care of equipment after treatment

Instructional Strategies

1. Pretest and/or review on anatomy and physiology of nasopharynx; communication and observation skills; routines for recording and reporting; routines for verification of doctor's orders and patient's identity; routine procedure and techniques for hand washing.
2. Slides, filmstrips, films, videotapes, and/or mediated programmed instruction (individual or group) on procedures, techniques, and routines for giving throat irrigation and gargle.
3. Hardcover programmed instruction
4. Lecture
5. Discussion
6. Demonstration
7. Practice in simulated patient care unit
8. Practice in work situation
9. Study assignments
10. Written exercises

Training Aids

1. Filmstrips/films/videotapes
2. Mediated programmed instruction
3. Hardcover programmed instruction
4. Slides
5. Chalk board
6. Wall charts
7. Anatomical models
8. Equipment and supplies
9. Instructor's guide
10. Student syllabus
11. References

Examination Modes

1. Response in classroom
2. Paper and pencil test
3. Rating on performance in simulated practice
4. Rating on performance in work situation (feedback)
5. Oral quiz on knowledge related to performance in simulated practice and/or work situation (feedback)

Training Time

0:30 hour didactic

0:30 hour supervised practice

LEARNING MODULE IO3
OXYGEN, CARBON DIOXIDE, AND HUMIDITY THERAPY

Tasks

- 320328 Cross check medication and treatment cards with KARDEX and doctor's orders
- 110063 Verify identification of patient, e.g., for treatment, medications, examination
- 250025 Read equipment manuals for operation and maintenance of equipment
- 120080 Inform patient of procedures required prior to/during examination/test/treatment
- 150078 Ask patient/check chart for contraindication for treatment/procedure/test
- 120010 Explain/answer patient's questions regarding examination/test/treatment/procedures
- 120046 Reassure/calm apprehensive/anxious patient
- 130436 Evaluate patient's complaints/symptoms of pain
- _____ Wash hands prior to/after patient care, medications, treatments, examination, procedures, collecting and handling specimens
- 110123 Position patient who has difficulty breathing
- 140086 Give oxygen therapy, i.e., cannula, catheter/mask
- 140290 Give oxygen therapy via tent
- _____ Give moisturized oxygen through tracheostomy tube
- 140289 Give carbon dioxide inhalation therapy
- 140320 Administer/provide trilene mask to patient
- _____ Give oxygen and humidity therapy by croupette
- 140091 Give steam/mist treatment
- 120316 Teach patient to cough and deep breathe
- 140288 Treat patient/personnel who hyperventilate, e.g., give breathing instructions, carbon dioxide
- 130382 Observe/record patient's physical/emotional response to treatment/diagnostic procedures
- 230005 Check pressurized tanks for quantity of gas, e.g., oxygen, helium
- 342117 Check compressed gas tanks for leak, e.g., oxygen
- 342108 Inspect breathing masks (oxygen or gas) for malfunction
- 342102 Check equipment for electrical hazards and grounds

- 150069 Give/receive verbal reports about patient
- 150035 Give report on changes/special care/treatments/tests for patient
- 150013 Make suggestion regarding patient care, e.g., need of medication, treatment
- 150082 Suggest changes in nursing care plan for patient
- 150102 Initiate and implement change in patient care plan
- 150064 Write nursing notes

Performance Objective (Stimulus)

When assigned by the physician, nurse, or senior corpsman/technician to administer oxygen, carbon dioxide, and humidity therapy prescribed by the physician.

Performance Objective (Behavior)

The corpsman/technician will check for due orders or need for prn orders; verify the orders and the patient's identity; read equipment manuals for operation and maintenance of equipment; inform the patient about the treatment and allay any apprehensions of the patient about receiving oxygen, carbon dioxide or humidity therapy; check for any contraindications for the treatment; wash his hands; collect, check, and ready equipment and supplies; give oxygen as prescribed by catheter, cannula, mask, face or body tent; give carbon dioxide by mask; in the case of hyperventilation, give carbon dioxide by mask or paper bag technique; administer steam or mist inhalations; give oxygen and humidity therapy by croupette; administer moisturized oxygen through tracheostomy tube; teach patient to cough and do breathing exercises; report to supervisory personnel the completion and results of the treatment, patient's response to treatment and his condition, and record on nursing notes; if indicated, suggest changes in patient care and modify nursing care plan to reflect the change; and apply safety measures in the use of all equipment.

Performance Objective (Conditions)

With indirect supervision and without assistance.

Performance Objective (Criteria)

In accordance with established standard procedures, techniques, and routines.

Performance Objective (Consequence)

Patient will receive the prescribed oxygen, carbon dioxide, and humidity therapy.

Performance Objective (Next Action)

Make patient as comfortable as possible, monitor continuous oxygen therapy.

Knowledge and Skills

1. Purpose of oxygen therapy by catheter, nasal inhalator, mask, face and body tent; of carbon dioxide therapy; of humidity therapy; and oxygen and humidity therapy.
2. Anatomy and physiology of respiratory system and relationship to circulatory system.
3. Communication techniques for giving information to and eliciting it from the patient and reporting to supervisory personnel.
4. Observation techniques for evaluating the patient's condition and response to treatment and proper working of equipment.
5. Routine for verification of doctor's orders and patient's identity
6. Patient's diagnosis, therapy, and condition as related to receiving oxygen, carbon dioxide, and steam inhalation.
7. Contraindication for any of the above treatments
8. Procedure, techniques, and routines for administering oxygen therapy by catheter, cannula, mask, face and body tent; carbon dioxide by mask; using paper or plastic bag to give carbon dioxide for hyperventilation; steam or mist inhalations; using croupette for giving oxygen and regulating humidity and administering oxygen through tracheostomy tube; maintaining and operating equipment.
9. Instructional techniques for teaching patient
10. Precautionary measures relative to the use of oxygen and carbon dioxide; also, steam inhalations with children.
11. Routine and techniques for suggesting changes in patient care and modifying nursing care plan when changes are made in patient care.
12. Routines and procedures for clean up and care of equipment after use

Instructional Strategies

1. Pretest and/or review on anatomy and physiology of respiratory system and relationship to circulatory system; routines for verifying doctor's orders and patient's identity; routines for reporting and recording; positioning the patient to facilitate breathing; communication, observation, and instructional skills.
2. Slides, filmstrips, films, videotapes, and/or mediated programmed instruction (individual or group) on nature and characteristics of oxygen and carbon dioxide; purpose, procedure, techniques, routines, and contraindications for oxygen administered by catheter, cannula, mask, face and body tents, with controlled humidity and into tracheostomy tube; for carbon dioxide administered by face mask and paper or plastic bag. Equipment operation and maintenance with emphasis on safety.
3. Hardcover programmed instruction
4. Lecture
5. Discussion
6. Demonstration
7. Practice in simulated patient care unit
8. Practice in work situation
9. Study assignments
10. Written exercises

Training Aids

1. Filmstrips/films/videotapes
2. Mediated programmed instruction
3. Hardcover programmed instruction
4. Slides
5. Wall charts
6. Chalk board
7. Anatomical models
8. Equipment and supplies
9. Instructor's guide
10. Student syllabus
11. References

Examination Modes

1. Response in classroom
2. Paper and pencil test
3. Rating on performance in simulated practice
4. Rating on performance in work situation (feedback)
5. Oral quiz on knowledge related to performance in simulated practice and/or work situation (feedback)

Training Time

- 1:30 hours didactic
- 1:30 hours supervised practice

LEARNING MODULE IO4
INTERMITTENT POSITIVE PRESSURE BREATHING THERAPY

Tasks

- 320328 Cross check medication and treatment cards with KARDEX and doctor's orders
- 110063 Verify identification of patient, e.g., for treatment, medications, examination
- 250025 Read equipment manuals for operation and maintenance of equipment
- 120080 Inform patient of procedures required prior to/during examination/test/treatment
- 150078 Ask patient/check chart for contraindication for treatment/procedure/test
- 120010 Explain/answer patient's questions regarding examination/test/treatment/procedures
- 120046 Reassure/calm apprehensive/anxious patient
- 130436 Evaluate patient's complaints/symptoms of pain
- _____ Wash hands prior to/after patient care, medications, treatments, examination, procedures, collecting and handling specimens
- 110123 Position patient who has difficulty breathing
- 342117 Check compressed gas tanks for leak, e.g., oxygen
- 140280 Instill medication into tube, machine, e.g., tracheotomy tube, catheters, I.P.P.B. machine
- 140081 Give I.P.P.B. treatment
- 120316 Teach patient to cough and deep breathe
- 130382 Observe/record patient's physical/emotional response to treatment/diagnostic procedures
- 150069 Give/receive verbal reports about patient
- 150035 Give report on changes/special care/treatments/tests for patient
- 150013 Make suggestion regarding patient care, e.g., need of medication, treatment
- 150082 Suggest changes in nursing care plan for patient
- 150102 Initiate and implement change in patient care plan
- 150064 Write nursing notes

Performance Objective (Stimulus)

When assigned by the physician, nurse, or senior corpsman/technician to administer intermittent positive pressure breathing (I.P.P.B.) prescribed by the physician.

Performance Objective (Behavior)

The corpsman/technician will check for due orders or the need for prn orders; verify the doctor's orders and patient's identity; read equipment manuals for operation and maintenance of Bennett and other positive pressure breathing units; inform the patient about the treatment and allay his apprehensions regarding it; check for any contraindication for the treatment; wash hands; collect, check, and ready equipment and supplies for giving I.P.P.B.; give I.P.P.B.; teach patient to cough and do breathing exercises; report to supervisory personnel the treatment, patient response to it, and patient's condition and record on nursing notes; and suggest needed changes in the patient's care and modify nursing care plan to reflect the changes.

Performance Objective (Conditions)

With selective supervision and without assistance.

Performance Objective (Criteria)

According to established standard procedures, techniques, and routines.

Performance Objective (Consequence)

Patient will receive prescribed I.P.P.B. treatment.

Performance Objective (Next Action)

Make patient as comfortable as possible.

Knowledge and Skills

1. Purpose of I.P.P.B. treatment
2. Anatomy and physiology of respiratory tract and relationship to circulatory tract

3. Communication techniques for giving information to and eliciting it from patient and reporting to supervisory personnel.
4. Observation techniques for evaluating the patient's condition and response to treatment, and for determining that equipment works properly.
5. Routine for verification of doctor's orders and patient's identity
6. Patient's diagnosis, therapy, and condition as related to I.P.P.B. treatment
7. Contraindications for I.P.P.B.
8. Procedures, techniques and routines for giving I.P.P.B.; operating and maintaining equipment, and recording on nursing notes and nursing care plan.
9. Instructional techniques for teaching patient
10. Precautionary measures relative to I.P.P.B. treatment and use of equipment
11. Routine and techniques for suggesting changes in patient care and for modifying nursing care plan to reflect changes.
12. Routines and procedures for clean up and care of equipment

Instructional Strategies

1. Pretest and/or review on anatomy and physiology of respiratory system and relationship to circulatory system; routines for verifying doctor's orders and patient's identity, routines for reporting and recording; routines, procedures, and techniques for hand washing; procedures and techniques for coughing and deep breathing; positioning the patient; communication, observation, and instructional skills.
2. Slides, filmstrips, films, videotapes, and/or mediated programmed instruction (individual or group) on purpose, procedure, techniques, routines, and contraindications and precautions for I.P.P.B. treatment; operation and maintenance of I.P.P.B. equipment and safety measures.
3. Hardcover programmed instruction
4. Lecture
5. Discussion
6. Demonstration
7. Practice in simulated patient care unit
8. Practice in work situation
9. Study assignments
10. Written exercises

Training Aids

1. Filmstrips/films/videotapes
2. Mediated programmed instruction
3. Hardcover programmed instruction
4. Slides
5. Wall charts
6. Chalk board
7. Anatomical models
8. Equipment and supplies
9. Instructor's guide
10. Student syllabus
11. References

Examination Modes

1. Response in classroom
2. Paper and pencil test
3. Rating on performance in simulated practice
4. Rating on performance in work situation (feedback)
5. Oral quiz on knowledge related to performance in simulated practice and/or work situation (feedback)

Training Time

- 0:30 hour didactic
- 0:30 hour supervised practice

LEARNING MODULE IO5
UPPER RESPIRATORY TRACT: SUCTIONING OF

Tasks

- 320328 Cross check medication and treatment cards with KARDEX and doctor's orders
- 110063 Verify identification of patient, e.g., for treatment, medications, examination
- 250025 Read equipment manuals for operation and maintenance of equipment
- 120080 Inform patient of procedures required prior to/during examination/test/treatment
- 150078 Ask patient/check chart for contraindication for treatment/procedure/test
- 120010 Explain/answer patient's questions regarding examination/test/treatment/procedures
- 120046 Reassure/calm apprehensive/anxious patient
- 130436 Evaluate patient's complaints/symptoms of pain
- Wash hands prior to/after patient care, medications, treatments, examination, procedures, collecting and handling specimens
- 110123 Position patient who has difficulty breathing
- 130019 Check patient's airway for patency/obstruction
- 140276 Suction nasal/oral passage
- 140172 Suction trachea, i.e., deep endotracheal suction
- 120316 Teach patient to cough and deep breathe
- 130382 Observe/record patient's physical/emotional response to treatment/diagnostic procedures
- 150069 Give/receive verbal reports about patient
- 150035 Give report on changes/special care/treatments/tests for patient
- 150013 Make suggestion regarding patient care, e.g., need of medication, treatment
- 150082 Suggest changes in nursing care plan for patient
- 150102 Initiate and implement change in patient care plan
- 150064 Write nursing notes

Performance Objective (Stimulus)

When assigned by the doctor, nurse, or senior corpsman/technician to suction the upper respiratory tract as prescribed by the physician.

Performance Objective (Behavior)

The corpsman/technician will check for due orders or the need for prn orders; verify the doctor's orders and patient's identity; read equipment manuals for operating and maintaining suction machines such as automatic and thermatic Gomco, Stedman, and Chaffin Pratt; inform the patient about the treatment and allay his apprehensions regarding it; check for any contraindications for suctioning the nasopharynx and/or trachea; wash hands; collect, check, and ready equipment and supplies for suctioning; position the patient and suction nasopharynx and/or trachea; teach the patient to cough and do breathing exercises; report to supervisory personnel the treatment and the patient's response and condition and record on nursing notes; and suggest any needed changes in the patient's care and modify nursing care plan to reflect changes.

Performance Objective (Conditions)

With selective supervision and without assistance.

Performance Objective (Criteria)

According to established standard procedures, techniques, and routines.

Performance Objective (Consequence)

Patient will receive prescribed nasopharynx and/or tracheal suction.

Performance Objective (Next Action)

Make patient as comfortable as possible.

Knowledge and Skills

1. Purpose of nasopharynx and/or tracheal suction
2. Anatomy and physiology of respiratory tract and relationship to circulatory system
3. Communication techniques for giving information to and eliciting it from patient, reassuring patient, and reporting to supervisory personnel.
4. Observation techniques for evaluating the patient's condition and response to treatment and proper functioning of suction equipment.
5. Routines for verification of doctor's orders and patient's identity

6. Patient's diagnosis, therapy, and condition as related to nasopharynx and tracheal suction
7. Contraindications for nasopharynx and/or tracheal suction
8. Procedures, techniques, and routines for performing nasopharynx and tracheal suction, operation and maintenance of equipment, and recording on nursing notes and nursing care plan.
9. Instructional techniques for teaching patient
10. Precautionary measures relative to suctioning procedure and use of equipment
11. Routine and techniques for suggesting changes in patient care and modifying nursing care plan to reflect changes.
12. Routines and procedures for clean up and care of equipment.

Instructional Strategies

1. Pretest and/or review on anatomy and physiology of respiratory system and relationship to circulatory system; routines for verifying doctor's orders and patient's identity; procedures and techniques for coughing and deep breathing; routines for reporting and recording; and communication, observation, and instructional skills.
2. Slides, filmstrips, films, videotapes, and/or mediated programmed instruction (individual or group) on purpose, procedure, techniques, routines, contraindications, and precautions for suctioning nasopharynx and/or trachea; operation, maintenance, and safety measures for commonly used suction machines such as Gomco, Stedman, and Chaffin Pratt.
3. Hardcover programmed instruction
4. Lecture
5. Discussion
6. Demonstration
7. Practice in simulated patient care unit
8. Practice in work situation
9. Study assignments
10. Written exercises

Training Aids

1. Filmstrips/films/videotapes
2. Mediated programmed instruction
3. Hardcover programmed instruction
4. Slides

5. Wall charts
6. Chalk board
7. Anatomical models
8. Equipment and supplies
9. Instructor's guide
10. Student syllabus
11. References

Examination Modes

1. Response in classroom
2. Paper and pencil test
3. Rating on performance in simulated practice
4. Rating on performance in work situation (feedback)
5. Oral quiz on knowledge related to performance in simulated practice and/or work situation (feedback)

Training Time

- 0:30 hour didactic
- 0:30 hour supervised practice

LEARNING MODULE 106
CHEST PHYSICAL THERAPY

Tasks

- 320328 Cross check medication and treatment cards with KARDEX and doctor's orders
- 110063 Verify identification of patient, e.g., for treatment, medications, examination
- 120080 Inform patient of procedures required prior to/during examination/test/treatment
- 150078 Ask patient/check chart for contraindication for treatment/procedure/test
- 120010 Explain/answer patient's questions regarding examination/test/treatment/procedures
- 120046 Reassure/calm apprehensive/anxious patient
- 130436 Evaluate patient's complaints/symptoms of pain
- _____ Wash hands prior to/after patient care, medications, treatments, examination, procedures, collecting and handling specimens
- 110123 Position patient who has difficulty breathing
- 120320 Teach postural drainage exercises
- 140378 Place patient in postural drainage position
- 140296 Perform chest vibrations and cupping treatment, i.e., chest physiotherapy
- 120038 Teach patient breathing exercises
- 120316 Teach patient to cough and deep breathe
- 130382 Observe/record patient's physical/emotional response to treatment/diagnostic procedures
- 150069 Give/receive verbal reports about patient
- 150035 Give report on changes/special care/treatments/tests for patient
- 150013 Make suggestion regarding patient care, e.g., need of medication, treatment
- 150082 Suggest changes in nursing care plan for patient
- 150102 Initiate and implement change in patient care plan
- 150064 Write nursing notes

Performance Objective (Stimulus)

When assigned by the physician, nurse, senior corpsman/technician to give chest physical therapy prescribed by the physician.

Performance Objective (Behavior)

The corpsman/technician will check for due orders or the need for prn orders; verify the doctor's orders and patient's identity; inform the patient about the treatment and allay any apprehensions of the patient about receiving chest physical therapy; check for any contraindications for the treatment; wash his hands; teach, position, and assist the patient to do postural drainage; by percussion or vibration assist in removal of secretions; give vibration treatment synchronized with mechanical ventilator therapy; teach patient diaphragmatic, unilateral basilar restrictive, and bilateral basilar chest expansion exercises; report to supervisory personnel completion and results of treatment; patient's response to treatment and his condition and record on nursing notes; and if indicated, make suggestions for changes in patient care and modify nursing care plan to reflect the changes.

Performance Objective (Conditions)

With selective supervision and with or without assistance, depending on condition of the patient.

Performance Objective (Criteria)

In accordance with established standard procedures, techniques, and routines.

Performance Objective (Consequence)

Patient will receive prescribed chest physical therapy as set forth on "Chest Physical Therapy Instruction Sheet."

Performance Objective (Next Action)

Make patient as comfortable as possible.

Knowledge and Skills

1. Purpose of chest physical therapy
2. Anatomy and physiology of respiratory system
3. Communication techniques for eliciting information from and giving it to the patient, reassuring the patient, and reporting to supervisory personnel.
4. Observation techniques for evaluating the patient's condition and response to treatment.
5. Routines for verification of doctor's orders and patient's identity
6. Patient's diagnosis, therapy, and condition as related to receiving chest physical therapy.
7. Contraindication for specific chest physical therapy
8. Procedures, techniques, and routines for positioning patient in bed to enhance respiratory function; for teaching diaphragmatic, unilateral basilar restrictive, and bilateral basilar chest expansion exercises; for teaching and assisting patient with postural drainage; manual percussion and vibration techniques for assisting in secretion removal; vibration synchronized with mechanical ventilator treatment for secretion removal; and recording on nursing notes and nursing care plan.
9. Instructional techniques for teaching the patient
10. Precautionary measures relative to giving chest physical therapy
11. Routine and techniques for suggesting changes in patient care and modifying nursing care plan to reflect changes.

Instructional Strategies

1. Pretest and/or review on anatomy and physiology of respiratory system and relationship to circulatory system; routines for verifying doctor's orders and patient's identity; procedures and techniques for coughing and deep breathing; routines for reporting and recording; and communication, observation, and instructional skills.
2. Slides, filmstrips, films, videotapes, and/or mediated programmed instruction (individual or group) on procedures, techniques, routines, contraindications, and precautions for positioning patient in bed; teaching and directing diaphragmatic, unilateral basilar restrictive, and bilateral basilar chest expansion exercises; teaching and directing postural drainage; doing manual percussion to promote secretion removal and doing manual vibrations with and without mechanical ventilator to promote secretion removal.
3. Hardcover programmed instruction
4. Lecture
5. Discussion

6. Demonstration
7. Practice in simulated patient care unit
8. Practice in work situation
9. Study assignments
10. Written exercises

Training Aids

1. Filmstrips/films/videotapes
2. Mediated programmed instruction
3. Hardcover programmed instruction
4. Slides
5. Wall charts
6. Chalk board
7. Anatomical models
8. Equipment and supplies
9. Instructor's guide
10. Student syllabus
11. References

Examination Modes

1. Response in classroom
2. Paper and pencil test
3. Rating on performance in simulated practice
4. Rating on performance in work situation (feedback)
5. Oral quiz on knowledge related to performance in simulated practice and/or work situation (feedback)

Training Time

0:45 hour didactic

1:00 hour supervised practice

LEARNING MODULE 107
TRACHEOTOMY CARE

Tasks

- 320328 Cross check medication and treatment cards with KARDEX and doctor's orders
- 110063 Verify identification of patient, e.g., for treatment, medications, examination
- 250025 Read equipment manuals for operation and maintenance of equipment
- 120080 Inform patient of procedures required prior to/during examination/test/treatment
- 150078 Ask patient/check chart for contraindication for treatment/procedure/test
- 120010 Explain/answer patient's questions regarding examination/test/treatment/procedures
- 120046 Reassure/calm apprehensive/anxious patient
- 130436 Evaluate patient's complaints/symptoms of pain
- _____ Wash hands prior to/after patient care, medications, treatments, examination, procedures, collecting and handling specimens
- 110123 Position patient who has difficulty breathing
- 140095 Give tracheotomy care, e.g., remove and clean inner cannula, suction, inflate/deflate cuff
- _____ Give the patient deep lung inflations using oxygen and ventilating bag or ventilators
- 140020 Apply/change sterile dressings
- 140086 Give oxygen therapy, i.e., cannula, catheter/mask
- _____ Give moisturized oxygen through tracheostomy tube
- 130382 Observe/record patient's physical/emotional response to treatment/diagnostic procedures
- 342102 Check equipment for electrical hazards and grounds
- 150069 Give/receive verbal reports about patient
- 150035 Give report on changes/special care/treatments/tests for patient
- 150013 Make suggestion regarding patient care, e.g., need of medication, treatment
- 150082 Suggest changes in nursing care plan for patient
- 150102 Initiate and implement change in patient care plan
- 150064 Write nursing notes

Performance Objective (Stimulus)

When assigned by the physician, nurse, or senior corpsman/technician to give tracheotomy care prescribed by the physician.

Performance Objective (Behavior)

The corpsman/technician will check for due orders or the need for prn orders; verify the doctor's orders and the patient's identity; read equipment manuals for the operation and maintenance of suction machine, ventilators, and oxygen equipment; inform the patient about the treatment and allay the patient's apprehension relative to the treatment; check any contraindications relative to the treatment; collect, check, and ready the equipment and supplies for use; wash his hands; position the patient; give tracheotomy tube care; give deep lung inflation using oxygen and ventilating bag or ventilators; change tracheostomy dressing; give moisturized oxygen; report to supervisory personnel the completion and results of the treatment, patient's condition and response to treatment and record on nursing notes; and if indicated, suggest changes in patient care and modify nursing care plan to reflect the change.

Performance Objective (Conditions)

With selective supervision and without assistance.

Performance Objective (Criteria)

In accordance with established standard procedures, techniques, and routines.

Performance Objective (Consequence)

Patient will receive the prescribed tracheotomy care.

Performance Objective (Next Action)

Make patient as comfortable as possible, clean up after procedure, and care for equipment.

Knowledge and Skills

1. Purpose of tracheotomy tube care, deep lung inflation, moisturized oxygen, and tracheostomy dressing.

2. Anatomy and physiology of trachea and surrounding tissue
3. Operation and maintenance of suction machine; oxygen equipment and ventilating bag; and ventilators such as Bird, Air Shield, MA-1, Emerson, and Bennett PR-1 and PR-2.
4. Sterile technique for dressings
5. Routines for verifying doctor's orders and patient's identity
6. Communication techniques for giving information to and eliciting it from the patient and reporting to the supervisory personnel.
7. Observation techniques for evaluating the patient's condition and response to tracheotomy tube care and deep lung inflation.
8. Patient's diagnosis, therapy, and condition as related to tracheotomy
9. Procedures, techniques, routines, contraindications, and precautions for tracheotomy tube care, deep lung inflations using manual sighing equipment or ventilator; giving moisturized oxygen; changing tracheostomy dressing; and recording on nursing notes and nursing care plan.
10. Precautionary measures relative to tracheotomy tube care and deep lung inflations
11. Routine and techniques for suggesting changes in patient care and modifying nursing care plan to reflect changes.
12. Routines and procedures for clean up and care of equipment

Instructional Strategies

1. Pretest and/or review on anatomy and physiology of respiratory system and relationship to circulatory system; routines for verifying doctor's orders and patient's identity; giving moisturized oxygen through tracheotomy tube; routines for reporting and recording; communication, observation, and instructional skills.
2. Slides, filmstrips, films, videotapes, and/or mediated programmed instruction (individual or group) on purpose, procedures, techniques, routines, contraindications, and precautions for giving tracheotomy tube care and deep lung inflation using oxygen and ventilating bag and ventilators; changing tracheostomy dressing; and operating and maintaining ventilators, e.g., MA-1, Emerson, Air Shield, Bennett PR-1 and PR-2, and Bird.
3. Hardcover programmed instruction
4. Lecture
5. Discussion
6. Demonstration
7. Practice in simulated patient care unit

8. Practice in work situation
9. Study assignments
10. Written exercises

Training Aids

1. Filmstrips/films/videotapes
2. Mediated programmed instruction
3. Hardcover programmed instruction
4. Slides
5. Wall charts
6. Chalk board
7. Anatomical models
8. Equipment and supplies
9. Instructor's guide
10. Student syllabus
11. References

Examination Modes

1. Response in classroom
2. Paper and pencil test
3. Rating on performance in simulated practice
4. Rating on performance in work situation (feedback)
5. Oral quiz on knowledge related to performance in simulated practice and/or work situation (feedback)

Training Time

- 1:00 hour didactic
- 1:00 hour supervised practice

TRAINING UNIT IP
GASTROINTESTINAL DYSFUNCTIONS: DIAGNOSTIC,
THERAPEUTIC AND REHABILITATIVE PROCEDURES

Learning Modules

- IP1. Observation and Examination of Gastrointestinal Conditions
- IP2. Colostomy and Ileostomy Care
- IP3. Gastrointestinal Intubation
- IP4. Feedings by Gastrointestinal Tube
- IP5. Gastrointestinal Irrigations
- IP6. Gastrointestinal Drainage With and Without Suction
- IP7. Lower Bowel Therapeutic Measures
- IP8. Gastrointestinal Tests and Examinations: Preparation for

Training Objective

Upon completion of this training unit, the learner must be able to observe, report, and record the signs and symptoms of gastrointestinal dysfunction; pass and remove types of gastrointestinal tubes; prepare patients for gastrointestinal tests and examinations including the aspiration of gastric fluids; give gastrointestinal tube feedings; initiate and maintain gastrointestinal irrigations; give cleansing and retention enemas and remove fecal impactions; and give colostomy and ileostomy care.

According to the requirements of the treatment or procedure, he will verify the doctor's orders and patient's identity; inform the patient about the treatment and procedure, answer his questions and reassure him; determine any contraindications for the treatment or procedure and notify appropriate supervisory personnel; wash his hands, collect, check, and prepare the required equipment and supplies; position and drape the patient; give the treatment and/or perform the procedure; encourage the patient to assist with own care such as tube feeding and colostomy care; change soiled clothing and linen if necessary following treatment and/or procedure; if indicated, suggest changes in nursing care and modify nursing care plan to reflect the

changes; and report to the supervisor and record on the nursing notes the treatment and/or procedures performed, the results and the patient's response, and the patient's condition.

The learner must be able to accomplish the foregoing with indirect or selective supervision and with or without an assistant, depending on the patient's condition and the requirements for assistance. He must be able to perform the foregoing in accordance with established standard routines, procedures, and techniques.

The patient will receive the prescribed treatment, care, preparation for diagnostic tests and examinations, and be observed and examined for signs and symptoms of gastrointestinal dysfunction.

Knowledge and Skills

1. Purpose of gastrointestinal intubations, tube feeding, drainage with or without suction, irrigations; cleansing and retention enemas; removal of fecal impactions; colostomy and ileostomy care; preparation for diagnostic tests and examinations; and observing gastrointestinal signs and symptoms and examining for abnormal conditions.
2. Anatomy and physiology of the gastrointestinal tract. Common gastrointestinal diseases and conditions related to observations and examinations; preparation for tests and examinations; therapeutic treatment and procedures, such as intubation, tube feedings, drainage care, irrigations, enemas, and colostomy and ileostomy care.
3. Communication techniques for giving information to and eliciting it from the patient and for reporting to supervisory personnel.
4. Observation techniques for observing the signs and symptoms of gastrointestinal dysfunction, the results of treatment given to the patient and the patient's response to treatment or procedure, and his condition.
5. Routine for verification of doctor's orders and patient's identity
6. Patient's diagnosis, therapy, and condition as related to the signs and symptoms of gastrointestinal tract dysfunction; preparation for tests and examination and such treatment as intubations, enemas, fecal impaction removal, and colostomy ileostomy care.
7. Criteria for contraindications for performing gastrointestinal tests and examinations; intubation, tube irrigations; and drainage with suction.
8. Procedures, techniques, and routines for preparing the patient for gastrointestinal tests and examinations; examining the patient; performing

gastric intubations, tube feedings, and tube irrigations; maintaining tube drainage with or without suction; giving enemas; removing fecal impaction; and giving colostomy and ileostomy care.

9. Precautionary measures relative to examination and tests, and to treatment and procedures set forth immediately above.
10. Routines and techniques for suggesting changes in patient care and for modifying nursing care plan to reflect changes.
11. Routines and procedures for clean up and care of equipment

Instructional Strategies

1. Pretest and/or review on anatomy and physiology of gastrointestinal tract; communication and observation skills; routine for verification of doctor's orders and patient's identity; routine for reporting and recording.
2. Slides, filmstrips, films, videotapes, and/or mediated programmed instruction (individual or group) on purpose, procedures, techniques, routines, and precautions for preparation for gastrointestinal tests and examinations, examining patient, intubating, tube feedings, tube irrigations, tube drainage with or without suction, enemas, removal of fecal impaction, and colostomy and ileostomy care; and relating patient diagnosis, therapy, and condition to examinations, treatment, and procedures.
3. Hardcover programmed instruction
4. Lecture
5. Discussion
6. Demonstration
7. Practice in simulated patient care unit
8. Practice in work situation
9. Study assignments
10. Written exercises

Training Aids

1. Filmstrips/films/videotapes
2. Mediated programmed instruction
3. Hardcover programmed instruction
4. Slides
5. Wall charts
6. Chalk board
7. Anatomical models

8. Equipment and supplies
9. Instructor's guide
10. Student syllabus
11. References

Examination Modes

1. Response in classroom
2. Paper and pencil test
3. Rating on performance in simulated practice
4. Rating on performance in work situation (feedback)
5. Oral quiz on knowledge related to performance in simulated practice and/or work situation (feedback)

Training Time

- 8:00 hours didactic
- 6:30 hours supervised practice

LEARNING MODULE IP1
OBSERVATION AND EXAMINATION OF GASTROINTESTINAL CONDITIONS

Tasks

- 110063 Verify identification of patient, e.g., for treatments, medications, examination
- 130388 Observe for/report or describe characteristics of urine, feces, vomitus, regurgitation
- 130431 Check/observe elimination patterns, e.g., frequency, urgency, and contents
- 130027 Observe for/report symptoms of diarrhea
- 130048 Observe for/report symptoms of intestinal worms
- 120080 Inform patient of procedures prior to/during examination/test/treatment
- 120010 Explain/answer patient's questions regarding examination/test/treatment/procedure
- 120046 Reassure/calm apprehensive/anxious patient
- 150141 Elicit information to ascertain patient's understanding of illness/treatment
- 120091 Explain/answer patient's questions regarding symptoms/disease/treatment
- _____ Wash hands prior to/after patient care, medications, treatments, examinations, procedure, specimen collecting and handling
- 134036 Evaluate patient's complaints/symptoms of pain
- 130046 Observe for/report symptoms of influenza
- 130043 Observe for/report symptoms of external hemorrhoids
- _____ Examine for fecal impaction
- 130244 Palpate (feel) abdomen for distension (hardness, softness)
- _____ Examine abdomen for painful areas
- 130253 Auscultate abdomen for bowel sounds
- 130382 Observe/record patient's physical/emotional response to treatment/diagnostic procedure
- 150073 Notify medical personnel of treatment needs of patient
- 150013 Make suggestions regarding patient care
- 150082 Suggest changes in patient's nursing care plan
- 150102 Initiate and implement changes in patient's nursing care plan
- 150064 Write nursing notes

Performance Objective (Stimulus)

When assigned by the physician, nurse, or senior corpsman/technician to give care to a patient or to make patient rounds and when a patient shows signs and symptoms or complains about abnormalities in the functions of his gastrointestinal tract.

Performance Objective (Behavior)

The corpsman/technician will verify the identification of the patient; observe or check bowel elimination patterns and the characteristics of eliminated regurgitation, vomitus, and feces; examine for swallowing reflex, infections of the mouth, influenza, external hemorrhoids and fecal impactions; and examine the abdomen for distension, painful areas, and bowel sounds; inform the patient about the examination, answer the patient's questions and reassure him, evaluate his complaints, and observe his response to the examination. He will notify his supervisor of the patient's needs; suggest changes in patient's care, and make the necessary changes on the nursing care plan and record his findings on the nursing notes.

Performance Objective (Conditions)

With indirect supervision and without assistance.

Performance Objective (Criteria)

Using good observation techniques and established standard examination procedures and techniques.

Performance Objective (Consequence)

Current status of patient's gastrointestinal condition will be identified.

Performance Objective (Next Action)

Make patient as comfortable as possible and initiate treatment if indicated.

Knowledge and Skills

1. Anatomy and physiology of gastrointestinal system
2. Purpose of observation and examination

3. Communication techniques for giving information to and eliciting it from the patient and reporting to supervisory personnel.
4. Observation techniques for assessing patient's condition and response to examination
5. Routine for verification of patient's identity
6. Patient's diagnosis, therapy, and condition as related to observations and examinations
7. Criteria for contraindications for examinations
8. Procedures, techniques, and routines for observing elimination patterns and characteristics of eliminated regurgitation, vomitus, and feces; examining for swallowing reflex, mouth infections, influenza, external hemorrhoids, fecal impactions and abdominal pain, distension and bowel sounds; and recording on the nursing notes and reporting to supervisor.
9. Precautionary measures relative to examinations
10. Routines and techniques for suggesting changes in patient care and for modifying nursing care plan to reflect changes.
11. Routines and procedures for clean up and care of equipment

Instructional Strategies

1. Pretest and/or review on anatomy and physiology of gastrointestinal tract; observation and communication skills; routine for verifying patient's identity; routines for reporting and recording; routine for modifying patient care plan.
2. Slides, filmstrips, films, videotapes, and/or mediated programmed instruction (individual or group) on purpose, procedures, techniques, and routines for observing elimination patterns and characteristics of eliminated regurgitation, vomitus, and feces; examining for swallowing reflex, mouth infections, influenza, external hemorrhoids, fecal impaction and abdominal pain, distension and bowel sounds.
3. Hardcover programmed instruction
4. Lecture
5. Discussion
6. Demonstration
7. Practice in simulated patient care unit
8. Practice in work situation
9. Study assignments
10. Written exercises

Training Aids

1. Filmstrips/films/videotapes
2. Mediated programmed instruction
3. Hardcover programmed instruction
4. Slides
5. Wall charts
6. Chalk board
7. Equipment and supplies
8. Instructor's guide
9. Student syllabus
10. References

Examination Modes

1. Response in classroom
2. Paper and pencil test
3. Rating on performance in simulated practice
4. Rating on performance in work situation (feedback)
5. Oral quiz on knowledge related to performance in simulated practice and/or work situation (feedback)

Training Time

- 1:00 hour didactic
- 0:20 hour supervised practice

LEARNING MODULE IP2
COLOSTOMY AND ILEOSTOMY CARE

Tasks

- 330328 Cross check medication and treatment cards with KARDEX and doctor's orders
- 110063 Verify identification of patient, e.g., for treatments, medications, examination
- 120080 Inform patient of procedures prior to/during examination/test/treatment
- 150078 Ask patient/check chart for contraindications for treatment/procedure/test
- 120010 Explain/answer patient's questions regarding examination/test/treatment/procedure
- 150141 Elicit information to ascertain patient's understanding of illness/treatment
- 120091 Explain/answer patient's questions regarding symptoms/disease/treatment
- 120046 Reassure/calm apprehensive/anxious patient
- _____ Wash hands prior to/after patient care, medications, treatments, examinations, procedures, specimen collecting and handling
- 110013 Drape/gown patient for treatment/examination
- 140321 Give care to patient with colostomy/ileostomy, e.g., apply dressings, special appliances, dilate stoma
- 120004 Reinforce patient's positive response to therapy
- 120293 Progressively lessen patient's dependency on medical personnel
- 120036 Encourage patient's independence and involvement in self-care
- 130346 Evaluate patient's complaints/symptoms of pain
- 130382 Observe/record patient's physical/emotional response to treatment/diagnostic procedure
- 110010 Clean and clothe patient after surgery, treatment, examination
- 110096 Change patient's soiled linen and clothing
- 150069 Give/receive verbal reports about patient
- 150035 Give report on changes/special care/treatments/tests for patient
- 150073 Notify medical personnel of treatment needs of patient
- 150013 Make suggestions regarding patient care
- 150082 Suggest changes in patient's nursing care plan
- 150102 Initiate and implement changes in patient's nursing care plan

150064 Write nursing notes

_____ Record on patient's nursing care plan

Performance Objective (Stimulus)

When assigned by a doctor, nurse, or senior corpsman/technician to give colostomy or ileostomy care to a patient as ordered by the physician and set forth in the nursing care plan.

Performance Objective (Behavior)

The corpsman/technician will verify the doctor's orders and patient's identity; inform the patient about his care, answer his questions and reassure him; determine any contraindications for the care and notify the supervisory personnel; collect, check, and prepare the required equipment and supplies; drape the patient; wash his hands; remove the dressing or appliance; cleanse the skin; dilate the stoma and reapply the dressing; evaluate the patient's condition and response to care; encourage patient to assist with care; change soiled clothing and/or linen; suggest changes in nursing care, if indicated, and modify nursing care plan to reflect changes; report to supervisory personnel the treatment and patient's response and condition, and record on nursing notes and nursing care plan.

Performance Objective (Conditions)

With indirect supervision and without assistance.

Performance Objective (Criteria)

In accordance with established standard procedures, techniques, and routines.

Performance Objective (Consequence)

Patient will receive the colostomy or ileostomy care prescribed by the physician and directed by the nursing care plan.

Performance Objective (Next Action)

Make the patient as comfortable as possible.

Knowledge and Skills

1. Purpose of colostomy care
2. Anatomy and physiology of gastrointestinal tract, especially the colon and ileum
3. Communication techniques for giving information to and eliciting it from the patient and for reporting to supervisory personnel.
4. Observation techniques for assessing the patient's condition and response to colostomy or ileostomy care.
5. Routine for verification of doctor's orders and patient's identity
6. Patient's diagnosis, therapy, and condition as related to colostomy and ileostomy care
7. Criteria for contraindications for colostomy and ileostomy care
8. Procedures, techniques, and routines for changing colostomy and ileostomy dressing or appliance, and dilating the stoma and recording on the nursing notes and nursing care plan.
9. Precautionary measures relative to colostomy and ileostomy care, including stoma dilation
10. Routines and techniques for suggesting changes in patient care and for modifying nursing care plan to reflect changes.
11. Routines and procedures for clean up and care of equipment

Instructional Strategies

1. Pretest and/or review on anatomy and physiology of gastrointestinal tract with emphasis on colon and ileum; observation and communication skills; verification of doctor's orders and patient's identity; routines for reporting and recording.
2. Slides, filmstrips, films, videotapes, and/or mediated programmed instruction (individual or group) on purpose, procedure, techniques, routines, and precautions for colostomy and ileostomy care, including stoma dilation; instructional techniques to ensure patient's independence in giving self-care.
3. Hardcover programmed instruction
4. Lecture
5. Discussion
6. Demonstration
7. Practice in simulated patient care unit
8. Practice in work situation

9. Study assignments
10. Written exercises

Training Aids

1. Filmstrips/films/videotapes
2. Mediated programmed instruction
3. Hardcover programmed instruction
4. Slides
5. Wall charts
6. Chalk board
7. Anatomical models
8. Equipment and supplies
9. Instructor's guide
10. Student syllabus
11. References

Examination Modes

1. Response in classroom
2. Paper and pencil test
3. Rating on performance in simulated practice
4. Rating on performance in work situation (feedback)
5. Oral quiz on knowledge related to performance in simulated practice and/or work situation (feedback)

Training Time

0:45 hour didactic

0:45 hour supervised practice

LEARNING MODULE IP3
GASTROINTESTINAL INTUBATION

Tasks

- 330328 Cross check medications and treatment card with KARDEX and doctor's orders
- 110063 Verify identification of patient, e.g., for treatments, medications, and examinations
- 120080 Inform patient of procedures prior to/during examination/test/treatment
- 150078 Ask patient/check chart for contraindications for treatment/procedure/test
- 120010 Explain/answer patient's questions regarding examination/test/treatment/procedure
- 120091 Explain/answer patient's questions regarding symptoms/disease/treatment
- 150141 Elicit information to ascertain patient's understanding of illness/treatment
- 120046 Reassure/calm apprehensive/anxious patient
- _____ Wash hands prior to/after patient care, medications, treatments, examinations, procedures, specimen collecting and handling
- 140214 Insert/remove nasogastric tube/Levine tube
- 140329 Insert/remove Ewald tube
- 140489 Insert/remove rectal tube
- _____ Insert/remove Miller-Abbott tube
- 140328 Advance Cantor, Miller-Abbott tube or string
- _____ Insert/remove Abbott-Rawson tube
- _____ Insert/remove Rehfuess tube
- _____ Insert/remove Jutte tube
- _____ Insert/remove Sawyer tube
- _____ Insert/remove Harris tube
- _____ Insert/remove Salem sump pump tube
- _____ Insert/remove Sengstaken-Blakemore tube
- 130436 Evaluate patient's complaints/symptoms of pain
- 130382 Observe/record patient's physical/emotional response to treatment/diagnostic procedure

150069 Give/receive verbal reports about patient
150035 Give report on changes/special care/treatments/tests for patient
150073 Notify medical personnel of treatment needs of patient
150013 Make suggestions regarding patient care
150082 Suggest changes in patient's nursing care plan
150102 Initiate and implement changes in patient's nursing care plan
150064 Write nursing notes
_____ Record on patient's nursing care plan

Performance Objective (Stimulus)

When assigned by the physician, nurse, or senior corpsman/technician to carry out or assist in carrying out a procedure ordered by the physician that requires the insertion and removal of a gastrointestinal tube.

Performance Objective (Behavior)

The corpsman/technician will verify the doctor's orders and patient identity; inform the patient about the procedure, answer his questions, and reassure him; determine any contraindications for the procedure and notify supervisory personnel; collect, check, and prepare the necessary equipment and supplies; pass the tube appropriate for the procedure or assist in passing it; suggest changes in nursing care and modify nursing care plan to reflect changes; report to supervisory personnel and record on the nursing notes the procedure, patient's response, and condition. He will remove the tube when the treatment is completed or when ordered by the physician.

Performance Objective (Conditions)

With selective supervision and without assistance unless patient's condition warrants assistance.

Performance Objective (Criteria)

In accordance with established standard procedures, techniques, and routines.

Performance Objective (Consequence)

Gastrointestinal tube will be inserted or removed as appropriate for the ordered treatment.

Performance Objective (Next Action)

Connect the tube, if indicated, to suction or to open or drain container and make the patient as comfortable as possible.

Knowledge and Skills

1. Purpose of gastrointestinal tubes - different types
2. Anatomy and physiology of the upper gastrointestinal tract
3. Communication techniques for giving information to and eliciting it from the patient and for reporting to supervisory personnel.
4. Observation techniques for assessing the patient's condition and response to passing and removing a gastrointestinal tube.
5. Routine for verification of doctor's orders and patient's identity
6. Patient's diagnosis, therapy, and condition as related to passing and removing a gastrointestinal tube.
7. Criteria for contraindication for passing and removing a gastrointestinal tube
8. Procedures, techniques, and routines for passing and removing different types of gastrointestinal tubes:

Levine - small stomach, for diagnosis and therapy

Ewald (gastric lavage) - large stomach, for washing stomach

Sawyer (larger version of Levine) - for diagnosis and therapy

Harris - intestinal, for drainage

Cantor - intestine, for drainage

Miller-Abbott - intestine, double lumen for suction and feeding

Abbott-Rawson - intestine, double lumen for suction and feeding

Rehfuss - stomach and intestine, to withdraw secretions

Jutte - stomach and intestine, to withdraw secretions

Colon (rectal) - rectal, for giving fluids and removing gas

and routines for recording on the nursing notes and the nursing care plan.

9. Precautionary measures relative to passing and removing gastrointestinal tubes; especially the intestinal tubes.

10. Routines and techniques for suggesting changes in patient care and for modifying nursing care plan to reflect changes.
11. Routines and procedures for clean up and care of equipment

Instructional Strategies

1. Pretest and/or review on anatomy and physiology of the upper gastrointestinal tract; observation and communication skills; verification of doctor's orders and patient's identity; routines for reporting and recording.
2. Slides, filmstrips, films, videotapes, and/or mediated programmed instruction (individual or group) on purpose, procedures, techniques, and routines for inserting and removing Levine, Ewald, Miller-Abbott, Abbott-Rawson, Reh fuss, Jutte, Sawyer, Harris, Salem sump pump, Sengshalen-Blakemore gastrointestinal tubes and for inserting and removing rectal tube.
3. Hardcover programmed instruction
4. Lecture
5. Discussion
6. Demonstration
7. Practice in simulated patient care unit
8. Practice in work situation
9. Study assignments
10. Written exercises

Training Aids

1. Filmstrips/films/videotapes
2. Mediated programmed instruction
3. Hardcover programmed instruction
4. Slides
5. Wall charts
6. Anatomical models
7. Equipment and supplies
8. Instructor's guide
9. Student syllabus
10. References

Examination Modes

1. Response in classroom
2. Paper and pencil test
3. Rating on performance in simulated practice
4. Rating on performance in work situation (feedback)
5. Oral quiz on knowledge related to performance in simulated practice and/or work situation (feedback)

Training Time

- 1:00 hour didactic
- 0:45 hour supervised practice

LEARNING MODULE IP4
FEEDINGS BY GASTROINTESTINAL TUBE

Tasks

- 330328 Cross check medications and treatment card with KARDEX and doctor's orders
- 110063 Verify identification of patient, e.g., for treatments, medications, examinations
- 120080 Inform patient of procedures prior to/during examination/test/treatment
- 150078 Ask patient/check chart for contraindications for treatment/procedure/test
- 120010 Explain/answer patient's questions regarding examination/test/treatment/procedure
- 150141 Elicit information to ascertain patient's understanding of illness/treatment
- 120091 Explain/answer patient's questions regarding symptoms/disease/treatment
- 120046 Reassure/calm apprehensive/anxious patient
- _____ Wash hands prior to/after patient care, medications, treatments, examinations, procedures, specimen collecting and handling
- 140013 Administer tube feeding, e.g., nasogastric or gastrostomy
- _____ Give a Murphy or Harris drip
- _____ Give a gastric lavage
- 130436 Evaluate patient's complaints/symptoms of pain
- 120004 Reinforce patient's positive response to therapy
- 120293 Progressively lessen patient's dependency on medical personnel
- 120036 Encourage patient's independence and involvement in self care
- 130382 Observe/record patient's physical/emotional response to treatment/diagnostic procedures
- 150069 Give/receive verbal reports about patient
- 150073 Notify medical personnel of treatment needs of patient
- 150013 Make suggestions regarding patient care
- 150082 Suggest changes in patient's nursing care plan
- 150102 Initiate and implement changes in patient's nursing care plan
- 150064 Write nursing notes
- _____ Record on patient's nursing care plan

Performance Objective (Stimulus)

When assigned by the physician, nurse, or senior corpsman/technician to give feedings by nasogastric, gastrostomy, enterostomy tubes and by Murphy or Harris drip.

Performance Objective (Behavior)

The corpsman/technician will verify the doctor's orders and the patient's identity; inform the patient about the procedure; answer his questions and reassure him; determine any contraindication for the feeding and notify supervisory personnel; wash his hands; collect, check, and prepare the necessary equipment and supplies and give the feeding by nasogastric, gastrostomy or enterostomy tubes, or Murphy or Harris drip. In cases of nasogastric, gastrostomy, or enterostomy feedings, encourage the patient to give his own and assist him as required. The corpsman/technician will suggest changes in nursing care and modify the nursing care plan to reflect the changes and report to supervisory personnel and record on the nursing notes the feeding and the patient's response and condition.

Performance Objective (Conditions)

With indirect supervision and with or without assistance, depending on the patient's condition.

Performance Objective (Criteria)

In accordance with established standard procedures, techniques, and routines.

Performance Objective (Consequence)

Patient will receive the ordered tube feeding or drip for nutritional maintenance.

Performance Objective (Next Action)

Make the patient as comfortable as possible.

Knowledge and Skills

1. Purpose of nasogastric, gastrostomy and enterostomy tube feedings, and Murphy and Harris drips.
2. Anatomy and physiology of gastrointestinal tract
3. Communication techniques for giving information to and eliciting it from the patient and for reporting to supervisory personnel.
4. Observation techniques for assessing the patient's condition and response to feeding or drip.
5. Routine for verification of doctor's orders and patient's identity
6. Patient's diagnosis, therapy, and condition as related to tube feedings, nutritional requirements, and oral hygiene.
7. Criteria for contraindications for tube feeding or drip
8. Procedures, techniques, and routines for giving a nasogastric, gastrostomy, and enterostomy tube feeding and Harris or Murphy drip, and recording on the nursing notes and nursing care plan.
9. Precautionary measures relative to nasogastric, gastrostomy and enterostomy tube feedings, and Harris or Murphy drip.
10. Routines and techniques for suggesting changes in patient care and for modifying nursing care plan to reflect changes.
11. Routines and procedures for clean up and care of equipment

Instructional Strategies

1. Pretest and/or review on anatomy and physiology of gastrointestinal tract; observation and communication skills; verification of doctor's orders and patient's identity; routines for reporting and recording.
2. Slides, filmstrips, films, videotapes, and/or mediated programmed instruction (individual or group) on purpose, procedure, and routines for giving nasogastric, gastrostomy and enterostomy feedings, and Harris or Murphy drips; instructional techniques to ensure patient's independence for giving tube feedings; patient's diagnosis, therapy, condition, and related nutrition.
3. Hardcover programmed instruction
4. Lecture
5. Discussion
6. Demonstration
7. Practice in simulated patient care units
8. Practice in work situation
9. Study assignments
10. Written exercises

Training Aids

1. Filmstrips/films/videotapes
2. Mediated programmed instruction
3. Hardcover programmed instruction
4. Slides
5. Wall charts
6. Chalk board
7. Anatomical models
8. Equipment and supplies
9. Instructor's guide
10. Student syllabus
11. References

Examination Modes

1. Response in classroom
2. Paper and pencil test
3. Rating on performance in simulated practice
4. Rating on performance in work situation (feedback)
5. Oral quiz on knowledge related to performance in simulated practice and/or work situation (feedback)

Training Time

- 0:45 hour didactic
- 0:45 hour supervised practice

LEARNING MODULE IP5
GASTROINTESTINAL IRRIGATIONS

Tasks

- 330328 Cross check medications and treatment card with KARDEX and doctor's orders
- 110063 Verify identification of patient, e.g., for treatments, medications, and examinations
- 120080 Inform patient of procedures prior to/during examination/test/treatment
- 150078 Ask patient/check chart for contraindications for treatment/procedure/test
- 120010 Explain/answer patient's questions regarding examination/test/treatment/procedure
- 150141 Elicit information to ascertain patient's understanding of illness/treatment
- 120091 Explain/answer patient's questions regarding symptoms/disease/treatment
- 120046 Reassure/calm apprehensive/anxious patient
- _____ Wash hands prior to/after patient care, medications, treatments, examinations, procedures, specimen collecting and handling
- 110013 Drape/gown patient for treatment/examination
- 140360 Irrigate mouth/oral cavity
- 140323 Lavage stomach, i.e., irrigate until clear
- 140324 Irrigate nasogastric, Cantor, Miller-Abbott tubes
- 140325 Irrigate cecostomy tube
- 140115 Irrigate colostomy tube
- 140335 Perform colonic irrigations
- 130436 Evaluate patient's complaints/symptoms of pain
- 130382 Observe/record patient's physical/emotional response to treatment/diagnostic procedure
- 110010 Clean and clothe patient after surgery, treatment, examination
- 110096 Change patient's soiled linen and clothing
- 150069 Give/receive verbal reports about patient
- 150035 Give report on changes/special care/treatment/tests for patient
- 150073 Notify medical personnel of treatments needs of patient
- 150013 Make suggestions regarding patient care
- 150082 Suggest changes in patient's nursing care plan

150102 Initiate and implement changes in patient's nursing care plan

150064 Write nursing notes

_____ Record on patient's nursing care plan

Performance Objective (Stimulus)

When assigned by the doctor, nurse, or senior corpsman/technician to perform gastrointestinal irrigations ordered by the physician.

Performance Objective (Behavior)

The corpsman/technician will verify the doctor's orders and patient's identity; inform the patient about the procedure; answer his questions and reassure him; determine any contraindications for the irrigation and notify supervisory personnel; collect, check, and prepare the required equipment and supplies for the irrigation; drape the patient; wash his hands; irrigate the mouth, nasogastric tube, cecostomy or colostomy tube, and give colonic irrigations; evaluate the patient's condition and response to the treatment; change any soiled clothing and/or linen; suggest changes in nursing care and modify nursing care plan to reflect changes; report to supervisory personnel and record on nursing notes the irrigation, irrigation results, patient's response, and condition.

Performance Objective (Conditions)

With selective supervision and with or without assistance, depending upon the patient's condition.

Performance Objective (Criteria)

In accordance with established standard procedures, techniques, and routines.

Performance Objective (Consequence)

Patient will receive the gastrointestinal irrigation ordered by the physician.

Performance Objective (Next Action)

Make the patient as comfortable as possible.

Knowledge and Skills

1. Purpose of irrigation of the mouth and of nasogastric, cecostomy, and colostomy tubes, and colonic irrigations.
2. Anatomy and physiology of the gastrointestinal tract
3. Communication techniques for giving information to and eliciting it from the patient and for reporting to supervisory personnel.
4. Observation techniques for assessing the patient's condition and response to the irrigation and the results of the irrigation.
5. Routine for verification of doctor's orders and patient's identity
6. Patient's diagnosis, therapy, and condition as related to the irrigation being administered.
7. Criteria for contraindication for oral irrigations; nasogastric, cecostomy and colostomy tube irrigations, and colonic irrigations.
8. Procedures, techniques, and routines for irrigation of the mouth; nasogastric, cecostomy and colostomy tubes, and the colon and recording on the nursing notes and nursing care plan.
9. Precautionary measures relative to irrigations of the mouth; nasogastric, cecostomy and colostomy tubes, and the colon.
10. Routines and techniques for suggesting changes in patient care and for modifying nursing care plan to reflect changes.
11. Routines and procedures for clean up and care of equipment.

Instructional Strategies

1. Pretest and/or review on anatomy and physiology of the gastrointestinal tract; observation and communication skills; verification of doctor's orders and patient's identity; routine for reporting and recording.
2. Slides, filmstrips, films, videotapes, and/or mediated programmed instruction (individual or group) on purpose, procedures, techniques, routines, and precautions for irrigations of the mouth; nasogastric, cecostomy and colostomy tubes, and the colon and recording on the nursing notes and nursing care plan.
3. Hardcover programmed instruction
4. Lecture
5. Discussion
6. Demonstration
7. Practice in simulated patient care unit
8. Practice in work situation
9. Study assignments
10. Written exercises

Training Aids

1. Filmstrips/films/videotapes
2. Mediated programmed instruction
3. Hardcover programmed instruction
4. Slides
5. Wall charts
6. Chalk board
7. Anatomical models
8. Equipment and supplies
9. Instructor's guide
10. Student syllabus
11. References

Examination Modes

1. Response in classroom
2. Paper and pencil test
3. Rating on performance in simulated practice
4. Rating on performance in work situation (feedback)
5. Oral quiz on knowledge related to performance in simulated practice and/or work situation (feedback)

Training Time

1:30 hours didactic

1:30 hours supervised practice

LEARNING MODULE IP6
GASTROINTESTINAL DRAINAGE WITH AND WITHOUT SUCTION

Tasks

- 330328 Cross check medications and treatment card with KARDEX and doctor's orders
- 110063 Verify identification of patient, e.g., for treatments, medications, and examinations
- 120080 Inform patient of procedures prior to/during examination/test/treatment
- 150078 Ask patient/check chart for contraindications for treatment/procedure/test
- 120010 Explain/answer patient's questions regarding examination/test/treatment/procedure
- 150141 Elicit information to ascertain patient's understanding of illness/treatment
- 120091 Explain/answer patient's questions regarding symptoms/disease/treatment
- 120046 Reassure/calm apprehensive/anxious patient
- _____ Wash hands prior to/after patient care, medications, treatments, examinations, procedures, specimen collecting and handling
- 250025 Read equipment manuals for operation and maintenance of equipment
- _____ Initiate and maintain T-tube drainage without suction
- _____ Initiate and maintain a Wangensteen suction
- _____ Initiate and maintain suction drainage of peritoneal cavity
- 140057 Connect drainage tube to drainage equipment, e.g., bags, bottles, basins
- 140268 Maintain drainage system, i.e., secure, position milk drainage bottles
- 130436 Evaluate patient's complaints/symptoms of pain
- 130382 Observe/record patient's physical/emotional response to treatment/diagnostic procedure
- 150069 Give/receive verbal reports about patient
- 150035 Give report on changes/special care/treatments/tests for patient
- 150073 Notify medical personnel of treatments needs of patient
- 150013 Make suggestions regarding patient care
- 150082 Suggest changes in patient's nursing care plan
- 150102 Initiate and implement changes in patient's nursing care plan
- 150064 Write nursing notes
- _____ Record on patient's nursing care plan

Performance Objective (Stimulus)

When assigned by the doctor, nurse, or senior corpsman/technician to start and maintain gastrointestinal drainage ordered by the physician.

Performance Objective (Behavior)

The corpsman/technician will verify the doctor's orders and patient's identity; read manuals for operating and maintaining suction equipment; if the patient is conscious, inform him about the procedure, answer his questions, and reassure him; determine any contraindications for the procedure and notify supervisory personnel; wash his hands; collect, check, and prepare necessary equipment and supplies; pass the proper gastrointestinal tube if required; connect the tube to the catch bag or bottle; start the suction machine and check frequently to ascertain that it is working; when necessary or at specified times, empty and clean the catch bag or bottle; measure drainage; suggest changes in nursing care and modify nursing care plan to reflect changes; report to supervisory personnel and record on nursing notes the initiation and maintenance of drainage system, change of bag or bottles, amount and characteristics of drainage, and patient's response and condition.

Performance Objective (Conditions)

With indirect supervision and without assistance.

Performance Objective (Criteria)

In accordance with established standard procedures, techniques, and routines.

Performance Objective (Consequence)

A functioning gastrointestinal drainage system, as ordered by the physician.

Performance Objective (Next Action)

Make the patient as comfortable as possible.

Knowledge and Skills

1. Purpose of Wangenstein suction, suction drainage of peritoneal cavity, and drainage without suction such as T-tube.

2. Anatomy and physiology of gastrointestinal system
3. Communication techniques for giving information to and eliciting it from the patient and for reporting to supervisory personnel.
4. Observation techniques for assessing the patient's condition and response to drainage system and to determine that the system is functioning and the amount and characteristics of the drainage.
5. Routine for verification of doctor's orders and patient's identity
6. Patient's diagnosis, therapy, and condition as related to the kind of drainage system; amount and characteristics of drainage; and his response to the drainage system.
7. Criteria for contraindications for initiating and/or maintaining the drainage system and for use of suction.
8. Procedures, techniques, and routines for initiating Wangensteen suction; connecting abdominal drainage tubes with or without suction; maintaining suction system; operation and maintenance of suction machines such as Gomer sump pump, Chapen, and Phalen hand pump; and recording on the nursing notes and nursing care plan.
9. Precautionary measures relative to gastrointestinal drainage system
10. Routines and techniques for suggesting changes in patient care and for modifying nursing care plan to reflect changes.
11. Routines and procedures for clean up and care of equipment

Instructional Strategies

1. Pretest and/or review on anatomy and physiology of gastrointestinal tract; observation and communication skills; verification of doctor's orders and patient's identity; procedures, techniques, and routines for gastric intubation; routines for reporting and recording.
2. Slides, filmstrips, films, videotapes, and/or mediated programmed instruction (individual or group) on purpose, procedure, techniques, routines, and precautions for initiating Wangensteen suction; connecting abdominal drainage tubes with and without suction; maintaining suction system; operation and maintenance of suction machines such as Gomer, sump pump, Chapen and Phalen hand pump.
3. Hardcover programmed instruction
4. Lecture
5. Discussion
6. Demonstration
7. Practice in simulated patient care unit
8. Practice in work situation

9. Study assignments
10. Written exercises

Training Aids

1. Filmstrips/films/videotapes
2. Mediated programmed instruction
3. Hardcover programmed instruction
4. Slides
5. Wall charts
6. Chalk board
7. Anatomical models
8. Equipment and supplies
9. Instructor's guide
10. Student syllabus
11. References

Examination Modes

1. Response in classroom
2. Paper and pencil test
3. Rating on performance in simulated practice
4. Rating on performance in work situation (feedback)
5. Oral quiz on knowledge related to performance in simulated practice and/or work situation (feedback)

Training Time

- 0:45 hour didactic
- 1:00 hour supervised practice

LEARNING MODULE IP7
LOWER BOWEL THERAPEUTIC MEASURES

Tasks

- 330328 Cross check medications and treatment card with KARDEX and doctor's orders
- 110063 Verify identification of patient, e.g., for treatments, medications, and examinations
- 120080 Inform patient of procedures prior to/during examination/test/treatment
- 150078 Ask patient/check chart for contraindications for treatment/procedure/test
- 120010 Explain/answer patient's questions regarding examination/test/treatment/procedure
- 150141 Elicit information to ascertain patient's understanding of illness/treatment
- 120091 Explain/answer patient's questions regarding symptoms/disease/treatment
- 120046 Reassure/calm apprehensive/anxious patient
- _____ Wash hands prior to/after patient care, medications, treatments, examinations, procedures, specimen collecting and handling
- 110013 Drape/gown patient for treatment/examination
- 140489 Insert/remove rectal tube
- 140071 Give enema
- 140322 Give medical/retention enema, e.g., oil retention
- 140151 Remove fecal impaction
- 130436 Evaluate patient's complaints/symptoms of pain
- 130382 Observe/record patient's physical/emotional response to treatment/diagnostic procedure
- 110096 Change patient's soiled linen and clothing
- 150069 Give/receive verbal reports about patient
- 150035 Give report on changes/special care/treatments/tests for patient
- 150073 Notify medical personnel of treatment needs of patient
- 150013 Make suggestions regarding patient care
- 150082 Suggest changes in patient's nursing care plan
- 150102 Initiate and implement changes in patient's nursing care plan
- 150064 Write nursing notes
- _____ Record on patient's nursing care plan

Performance Objective (Stimulus)

When assigned by the doctor, nurse, or senior corpsman/technician to insert and remove a rectal tube; give cleansing and retention enemas; and remove fecal impaction as ordered by the physician.

Performance Objective (Behavior)

The corpsman/technician will verify the doctor's orders and patient's identity; inform the patient about the treatment, answer his questions, and reassure him; determine any contraindications for the procedure and notify supervisory personnel; collect, check, and prepare the necessary equipment and supplies; wash his hands; position and drape the patient; insert and remove rectal tube; give cleansing or retention emema or remove manually the fecal impaction; change any soiled clothing or linen; evaluate the patient's response to the treatment; suggest changes in the patient's nursing care and modify nursing care plan to reflect the changes and report to supervisory personnel; record on the nursing notes the treatment given, and the patient's response and condition.

Performance Objective (Conditions)

With indirect supervision and with or without assistance, depending upon the patient's condition.

Performance Objective (Criteria)

In accordance with established standard procedures, techniques, and routines.

Performance Objective (Consequence)

Patient will be relieved of flatus and/or stool.

Performance Objective (Next Action)

Make the patient as comfortable as possible.

Knowledge and Skills

1. Purpose of inserted rectal tubes, enemas, and manual removal of fecal impaction
2. Anatomy and physiology of the gastrointestinal tract, especially the colon and rectum.

3. Communication techniques for giving information to and eliciting it from the patient and for reporting to supervisory personnel.
4. Observation techniques for assessing the patient's condition and response to the inserted rectal tube, cleansing or retention enemas, or removal of fecal impaction and the results of treatment.
5. Routine for verification of doctor's orders and patient's identity
6. Criteria for contraindications for inserting rectal tube; giving cleansing and retention enemas; and removing fecal impactions.
7. Procedures, techniques, and routines for passing and removing rectal tube; giving cleansing and retention enemas, including the most frequently used solutions for each; removing manually fecal impactions; and recording on the nursing notes and nursing care plan.
8. Precautionary measures relative to passing and removing rectal tubes; giving cleansing and retention enemas; and removing fecal impactions.
9. Routines and techniques for suggesting changes in patient care and for modifying nursing care plan to reflect changes.
10. Routines and procedures for clean up and care of equipment.

Instructional Strategies

1. Pretest and/or review on anatomy and physiology of gastrointestinal tract; observation and communication skills; verification of doctor's orders and patient's identity; routines for reporting and recording.
2. Slides, filmstrips, films, videotapes, and/or mediated programmed instruction (individual or group) on purpose, procedures, techniques, routines, and precautions for passing and removing rectal tubes; giving cleansing and retention enemas, including the most frequently used solutions for each; and removing manually fecal impactions.
3. Hardcover programmed instruction
4. Lecture
5. Discussion
6. Demonstration
7. Practice in simulated patient care unit
8. Practice in work situation
9. Study assignments
10. Written exercises

Training Aids

1. Filmstrips/films/videotapes
2. Mediated programmed instruction

3. Hardcover programmed instruction
4. Slides
5. Wall charts
6. Chalk board
7. Anatomical models
8. Equipment and supplies
9. Instructor's guide
10. Student syllabus
11. References

Examination Modes

1. Response in classroom
2. Paper and pencil test
3. Rating on performance in simulated practice
4. Rating on performance in work situation (feedback)
5. Oral quiz on knowledge related to performance in simulated practice and/or work situation (feedback)

Training Time

0:30 hour didactic

0:45 hour supervised practice

LEARNING MODULE IP8
GASTROINTESTINAL TESTS AND EXAMINATIONS: PREPARATION FOR

Tasks

- 330328 Cross check medications and treatment card with KARDEX and doctor's orders
- 110063 Verify identification of patient, e.g., for treatments, medications, examinations
- 120080 Inform patient of procedures prior to/during examination/test/treatment
- 150078 Ask patient/check chart for contraindications for treatment/procedure/test
- 120010 Explain/answer patient's questions regarding examination/test/treatment/procedure
- 120091 Explain/answer patient's questions regarding symptoms/disease/treatment
- 120046 Reassure/calm apprehensive/anxious patient
- 150141 Elicit information to ascertain patient's understanding of illness/treatment
- _____ Wash hands prior to/after patient care, medications, treatments, examinations, procedures, specimen collecting and handling
- 200003 Check instruments and supplies for sterilization indicator
- 130506 Perform nocturnal gastric analysis
- 259017 Aspirate gastric secretions for analysis
- _____ Prepare the patient for gastrointestinal (GI) series
- _____ Prepare the patient for Barium Enema (BA) series
- _____ Prepare the patient for gallbladder (GB) series
- _____ Prepare the patient for gastroscopic examination
- _____ Prepare the patient for sigmoidoscopic/protoscopic examination
- _____ Prepare the patient for esophagosopic examination
- _____ Prepare the patient for peritoneoscopic examination
- _____ Prepare the patient for serum protein tests
- _____ Prepare the patient for liver function tests
- 120018 Explain X-ray to patient
- 330143 Place special treatment tag over/on beds, e.g., fasting, force fluids
- 150142 Ascertain that patient has been prepped for test/treatment/examination
- 150021 Initiate and order diagnostic tests

- 130436 Evaluate patient's complaints/symptoms of pain
- 130382 Observe/record patient's physical/emotional response to treatment/
diagnostic procedure
- 150069 Give/receive verbal reports about patient
- 150035 Give report on changes/special care/treatments/tests for patient
- 150064 Write nursing notes
- _____ Record on patient's nursing care plan

Performance Objective (Stimulus)

When assigned by the doctor, nurse, or senior corpsman/technician to prepare the patient for a test or examination ordered by the physician.

Performance Objective (Behavior)

The corpsman/technician will verify the doctor's orders and patient's identity; inform the patient about the test or examination and the preparations for it, answer his questions and reassure him; determine any contraindications for the preparation and/or notify his supervisory personnel; wash his hands; collect and check his equipment and supplies and carry out the required preparations or specimen collection; send collected specimens to the laboratory; tag the patient's bed with special treatment sign; ascertain that all preparation steps have been accomplished; and report to his supervisor and record on the nursing notes and nursing care plan the preparation and/or specimen collection.

Performance Objective (Conditions)

With indirect supervision and without assistance.

Performance Objective (Criteria)

In accordance with established standard procedures, techniques, and routines.

Performance Objective (Consequence)

Patient will be prepared for tests and/or examination and specimen will be collected and sent to the laboratory.

Performance Objective (Next Action)

Make the patient as comfortable as possible.

Knowledge and Skills

1. Purpose of gastric analysis; GI, BA, and GB series; serum protein and liver function tests; and gastroscopic, sigmoidoscopic or protoscopic, esophagoscopic and peritoneoscopic examinations.
2. Anatomy and physiology of gastrointestinal tract
3. Communication techniques for giving information to and eliciting it from the patient and for reporting to supervisory personnel.
4. Observation techniques for assessing the patient's condition and response to preparation procedure.
5. Routine for verification of doctor's orders and patient's identity
6. Patient's diagnosis, therapy, and condition as related to preparation for test and examination requirements and for collecting of specimens.
7. Criteria for contraindications for the test or examination and/or the preparation for it; and for specimen collecting.
8. Procedures, techniques, and routines for preparing a patient for GI, BA, GB series, for serum protein and liver function tests, for gastroscopic, sigmoidoscopic or protoscopic, esophagoscopic and peritoneoscopic examinations; and for obtaining gastric juices for analysis, and recording on the nursing notes and nursing care plan.
9. Precautionary measures relative to preparation for tests and examinations and for obtaining gastric juices for specimen.
10. Routines and techniques for suggesting changes in patient care and for modifying nursing care plan to reflect changes.
11. Routines and procedures for clean up and care of equipment

Instructional Strategies

1. Pretest and/or review on anatomy and physiology of gastrointestinal tract; observation and communication skills; verification of doctor's orders and patient's identity; reporting and recording.
2. Slides, filmstrips, films, videotapes, and/or mediated programmed instruction (individual or group) on purpose, procedures, techniques, and routines for preparing a patient for GI, BA, or GB series; for serum protein and liver function tests; for gastroscopic, sigmoidoscopic or protoscopic, esophagoscopic and peritoneoscopic examinations; and for obtaining gastric juices for analysis; and for recording on the nursing notes and nursing care plan.

3. Hardcover programmed instruction
4. Lecture
5. Discussion
6. Demonstration
7. Practice in simulated patient care unit
8. Practice in work situation
9. Study assignments
10. Written exercises

Training Aids

1. Filmstrips/films/videotapes
2. Mediated programmed instruction
3. Hardcover programmed instruction
4. Slides
5. Wall charts
6. Chalk board
7. Anatomical models
8. Equipment and supplies
9. Instructor's guide
10. Student syllabus
11. References

Examination Modes

1. Response in classroom
2. Paper and pencil test
3. Rating on performance in simulated practice
4. Rating on performance in work situation (feedback)
5. Oral quiz on knowledge related to performance in simulated practice and/or work situation (feedback)

Training Time

- 1:00 hour didactic
- 0:30 hour supervised practice

TRAINING UNIT IQ
URINARY DYSFUNCTIONS: DIAGNOSTIC, THERAPEUTIC, AND
REHABILITATIVE PROCEDURES

Learning Modules

- IQ1. Observations and Examinations of Urinary Conditions
- IQ2. Assisting the Patient To Void by Credé Method
- IQ3. Catheterization of the Urinary Bladder
- IQ4. Urine Specimens: Collecting and Handling of Sterile
- IQ5. Urinary Gravity and Decompression Drainage
- IQ6. Urinary Tract Irrigations
- IQ7. Urinary Tract Diagnostic Tests and Examinations: Preparations for
- IQ8. Urine Specimens: Collecting and Handling of Urine for Special Tests
- IQ9. Urine Test: Performed in Patient Care Unit

Training Objective

Upon completion of this training unit, the learner must be able to observe, report, and record the signs and symptoms of urinary tract dysfunctions; assist the patient to void using the Credé method, catheterize the urinary bladder and collect and send sterile urine specimens to the laboratory; initiate, maintain, and terminate urethral catheter drainage and instill prescribed solutions into the bladder; maintain and give care required for cystostomy, nephrostomy, and ureterostomy drainage tubes; maintain and give care for urethral transplant drainage via sigmoid, ileum, and skin; irrigate urethral catheters, ureterostomy and other suprapubic tubes; maintain continuous irrigations; prepare the patient for such urinary tract examinations as intravenous urogram, retrograde pyelogram and aortography studies; collect urine specimens and send to the laboratory for such special examinations as Mosenthal, Addis sediment and phenolsulfonphthalein and perform urine tests on the ward unit for sugar, protein, acetone/ketone bodies, and specific gravity.

According to the requirements for the treatment or procedure, the learner must be able to verify the doctor's orders and patient's identity; inform

the patient about the treatment and/or procedure, answer his questions, and reassure him; determine any contraindications for the treatment and/or procedure and notify the supervisory personnel; collect, check, and prepare the required equipment and supplies; position and drape the patient; wash his hands; give the prescribed examination, treatment, and/or procedure; clean the patient and change his clothing and linens if necessary; if indicated, suggest changes in patient care and modify nursing care plan to reflect the changes; report to his supervisor as required the patient's condition, treatment given or procedure performed, the results of it, and the patient's response to it; and record the foregoing information on the nursing notes and check off on the nursing care plan.

The learner must be able to accomplish the foregoing with indirect and selective supervision and with or without an assistant, depending on the condition of the patient. He must be able to perform the foregoing according to established standard routines, procedures, and techniques.

The patient will receive the treatment and/or procedure prescribed by the physician; will be observed for signs and symptoms of urinary tract dysfunctions; and prescribed urine specimens will be collected and sent to the laboratory or tested on the ward unit.

Knowledge and Skills

1. Purpose of catheterization of the urinary bladder; use of Credé method for forced voiding; urinary tract gravity and decompression drainage and irrigations; preparation for urinary tract diagnostic tests and examinations; and the collecting and handling of urine specimens, sterile and unsterile, for special tests.
2. Anatomy and physiology of urinary tract and related circulatory system and common urinary tract diseases and conditions.
3. Communication techniques for giving information to and eliciting it from the patient and for reporting to supervisory personnel.
4. Observation techniques for observing the signs and symptoms of urinary tract dysfunctions, the result of treatments given to the patient, and the patient's response to treatment or procedure and his condition.

5. Routines for verification of doctor's orders and patient's identity
6. Patient's diagnosis, therapy, and condition as related to signs and symptoms of urinary tract dysfunctions; preparation for urinary tract tests and examinations; catheterization; Credé method for voiding; gravity and decompression drainage; irrigations and instillations; and special urine tests.
7. Criteria for contraindications for prescribed treatments and procedures of the urinary tract.
8. Procedures, techniques, and routines for preparation for urinary tract tests and examinations; observing and examining the patient for urinary symptoms; collecting and handling urine specimens for special test; performing certain urine tests; performing catheterizations, irrigations, and instillations; initiating, maintaining, and terminating gravity and decompression drainage; assisting the patient to void by the Credé method; and recording on the nursing notes and nursing care plan.
9. Precautionary measures relative to preparation for test and examination and for treatments and procedures set forth immediately above.
10. Routines and techniques for suggesting changes in patient care and for modifying nursing care plan to reflect changes.
11. Routines and procedures for clean up and care of equipment

Instructional Strategies

1. Pretest and/or review on anatomy and physiology of urinary tract and related circulatory system; communication and observation skills; routines for verifying doctor's orders and patient's identity; routines for sending collected urine specimens to the laboratory; routine for reporting and recording; routine for changing nursing care plan.
2. Slides, filmstrips, films, videotapes, and/or mediated programmed instruction (individual or group) on purpose, procedures, techniques, and routines for preparation for urinary tract tests and examinations; observing and examining the patient for urinary symptoms; collecting and handling urine specimens for special test; performing certain urine tests; performing catheterizations, irrigations, and instillations; initiating, maintaining, and terminating gravity and decompression drainage; assisting the patient to void by the Credé method; and recording on the nursing notes and nursing care plan.
3. Hardcover programmed instruction
4. Lecture
5. Discussion
6. Demonstration
7. Practice in simulated patient care unit

8. Practice in work situation
9. Study assignments

Training Aids

1. Filmstrips/films/videotapes
2. Mediated programmed instruction
3. Hardcover programmed instruction
4. Slides
5. Wall charts
6. Chalk board
7. Anatomical models
8. Equipment and supplies
9. Instructor's guide
10. Student syllabus
11. References

Examination Modes

1. Response in classroom
2. Paper and pencil test
3. Rating on performance in simulated practice
4. Rating on performance in work situation (feedback)
5. Oral quiz on knowledge related to performance in simulated practice and/or work situation (feedback)

Training Time

- 6:30 hours didactic
- 3:30 hours supervised practice

LEARNING MODULE 1Q1
OBSERVATIONS AND EXAMINATIONS OF URINARY CONDITIONS

Tasks

- 110063 Verify identification of patient, e.g., for treatments, medications, and examinations
- 130258 Observe for/report symptoms of urinary tract infections
- 130431 Check/observe elimination patterns, e.g., frequency, urgency, incontinence
- 130388 Observe/record or describe characteristics of urine, feces, vomitus, or regurgitation
- 130580 Observe for/report decreased urine outputs of patients susceptible to renal shutdown
- 130240 Check for edema (swelling) of extremities and eyes
- 150191 Evaluate patient's inability to void
- 130254 Palpate (feel) abdomen for distension (fullness)
- 120080 Inform patient of procedures prior to/during examination/test/treatment
- 120010 Explain/answer patient's questions regarding examination/test/treatment/procedure
- 150141 Elicit information to ascertain patient's understanding of illness/treatment
- 120046 Reassure/calm apprehensive/anxious patient
- _____ Wash hands prior to/after patient care, medications, treatments, examinations, procedures, specimen collecting and handling
- 130436 Evaluate patient's complaints/symptoms of pain
- 130430 Strain urine
- 130037 Examine for symptoms of venereal disease
- 130382 Observe/record patient's physical/emotional response to treatment/diagnostic procedure
- 120091 Explain/answer patient's questions regarding symptoms/disease/treatment
- 150013 Make suggestions regarding patient care
- 150082 Suggest changes in patient's nursing care plan
- 150102 Initiate and implement changes in patient's nursing care plan
- 150073 Notify medical personnel of treatment needs of patient
- 150064 Write nursing notes

Performance Objective (Stimulus)

When assigned by the doctor, nurse, or corpsman/technician to give care to a patient or to make patient rounds and when a patient complains about abnormalities in the functions of his urinary tract.

Performance Objective (Behavior)

The corpsman/technician will verify the identification of the patient; observe or check urinary elimination patterns, and the characteristics of urine output as to volume, color, odor, frequency, urgency, and incontinence; palpate his abdomen for distended bladder and observe extremities and eye sockets for edema; strain urine for stones; and examine for venereal disease discharge. He will inform the patient about the examination, answer the patient's questions and reassure him; evaluate his complaints and observe his response to the examination procedure. He will notify supervisory personnel about the patient's needs; suggest changes in his care, if indicated, and modify the nursing care plan to reflect the changes; and record his findings on the nursing notes.

Performance Objective (Conditions)

With indirect supervision and without assistance.

Performance Objective (Criteria)

In accordance with established standard procedures, techniques, and routines.

Performance Objective (Consequence)

Current status of patient's urinary functional condition will be identified.

Performance Objective (Next Action)

Make patient as comfortable as possible and initiate treatment if indicated.

Knowledge and Skills

1. Purpose of observation and examination of urinary tract functions and conditions

2. Anatomy and physiology of the urinary tract
3. Communication techniques for giving information to and eliciting it from the patient and for reporting to supervisory personnel.
4. Observation techniques for assessing the patient's condition, signs, and symptoms of urinary dysfunctions.
5. Routine for verification of doctor's orders and patient's identity
6. Patient's diagnosis, therapy, and condition as related to urinary functional condition.
7. Procedures, techniques, and routines for observing and checking urinary elimination patterns and characteristics of urinary output such as volume, color, odor, frequency, urgency, and incontinence; distended bladder, edema of extremities and eye sockets; urinary stones and symptoms of venereal disease; and recording on the nursing notes and nursing care plan.
8. Routines and techniques for suggesting changes in patient care and for modifying nursing care plan to reflect changes.
9. Routines and procedures for clean up and care of equipment

Instructional Strategies

1. Pretest and/or review on anatomy and physiology of urinary tract; communication and observation skills; verification of patient's identity; routines for reporting and recording.
2. Slides, filmstrips, films, videotapes, and/or mediated programmed instruction (individual or group) on purpose, procedure, techniques, and routines for observing and checking urinary elimination patterns and characteristics of urinary output such as volume, color, odor, frequency, urgency, and incontinence; distended bladder; edema of extremities and eye sockets; urinary stones and symptoms of venereal disease; and changes in patient care and for modifying nursing care plan to reflect changes.
3. Hardcover programmed instruction
4. Lecture
5. Discussion
6. Demonstration
7. Practice in simulated patient care unit
8. Practice in work situation
9. Study assignments
10. Written exercises

Training Aids

1. Filmstrips/films/videotapes
2. Mediated programmed instruction
3. Hardcover programmed instruction
4. Slides
5. Wall charts
6. Chalk board
7. Anatomical models
8. Equipment and supplies
9. Instructor's guide
10. Student syllabus
11. References

Examination Modes

1. Response in classroom
2. Paper and pencil test
3. Rating on performance in simulated practice
4. Rating on performance in work situation (feedback)
5. Oral quiz on knowledge related to performance in simulated practice and/or work situation (feedback)

Training Time

- 0:45 hour didactic
- 0:30 hour supervised practice

LEARNING MODULE IQ2
ASSISTING THE PATIENT TO VOID BY CREDÉ METHOD

Tasks

- 330328 Cross check medications and treatment card with KARDEX and doctor's orders
- 110063 Verify identification of patient, e.g., for treatments, medications, and examinations
- 120080 Inform patient of procedures prior to/during examination/test/treatment
- 150078 Ask patient/check chart for contraindications for treatment/procedure/test
- 120010 Explain/answer patient's questions regarding examination/test/treatment/procedure
- 150141 Elicit information to ascertain patient's understanding of illness/treatment
- 120091 Explain/answer patient's questions regarding symptoms/disease/treatment
- 120046 Reassure/calm apprehensive/anxious patient
- _____ Wash hands prior to/after patient care, medications, treatments, examinations, procedures, specimen collecting and handling
- 110013 Drape/gown patient for treatment/examination
- 140035 Assist patient to void by Credé method
- 130436 Evaluate patient's complaints/symptoms of pain
- 130382 Observe/record patient's physical/emotional response to treatment/diagnostic procedure
- 150069 Give/receive verbal reports about patient
- 150013 Make suggestions regarding patient care
- 150082 Suggest changes in patient's nursing care plan
- 150102 Initiate and implement changes in patient's nursing care plan
- 150064 Write nursing notes
- _____ Record on patient's nursing care plan

Performance Objective (Stimulus)

When assigned by the doctor, nurse, or senior corpsman/technician to manually express urine from the bladder as ordered by the physician.

Performance Objective (Behavior)

The corpsman/technician will verify the doctor's orders and patient's identity; inform the patient about the procedure, answer his questions, and reassure him; determine any contraindications for the procedure and notify supervisory personnel; collect, check, and prepare the required equipment and supplies; wash his hands; drape the patient; apply even manual pressure at head of bladder until emptied; evaluate patient's condition and response to procedure; if indicated, suggest changes in care and modify nursing care plan accordingly; and report to supervisory personnel and/or record on nursing notes the care given, patient's response, and condition.

Performance Objective (Conditions)

With indirect supervision and without assistance.

Performance Objective (Criteria)

In accordance with established standard procedures, techniques, and routines.

Performance Objective (Consequence)

Patient's bladder will be emptied.

Performance Objective (Next Action)

Make patient as comfortable as possible.

Knowledge and Skills

1. Purpose of Credé method of expressing urine from bladder
2. Anatomy and physiology of the urinary tract and related nervous system functions
3. Communication techniques for giving information to and eliciting it from the patient and for reporting to supervisory personnel.
4. Observation techniques for assessing the patient's condition and response to the manual expulsion of urine from the bladder.
5. Routine for verification of doctor's orders and patient's identity
6. Patient's diagnosis, therapy, and condition as related to the need for use of the Credé method of urine expulsion.

7. Criteria for contraindications for manual expulsion of urine from bladder using Credé method.
8. Procedures, techniques, and routines for manual expulsion of urine from bladder and recording on the nursing notes and nursing care plan.
9. Precautionary measures relative to use of Credé method for urine expulsion
10. Routines and techniques for suggesting changes in patient care and for modifying nursing care plan to reflect changes.
11. Routines and procedures for clean up and care of equipment

Instructional Strategies

1. Pretest and/or review on anatomy and physiology of urinary tract and related nervous system functions; communication and observation skills; verification of doctor's orders and patient's identity; and routines for reporting and recording.
2. Slides, filmstrips, films, videotapes, and/or mediated programmed instruction (individual or group) on procedure, techniques, routines, and precautions for using Credé method of urinary expulsion.
3. Hardcover programmed instruction
4. Lecture
5. Discussion
6. Demonstration
7. Practice in simulated patient care unit
8. Practice in work situation
9. Study assignments
10. Written exercises

Training Aids

1. Filmstrips/films/videotapes
2. Mediated programmed instruction
3. Hardcover programmed instruction
4. Slides
5. Wall charts
6. Chalk board
7. Anatomical models
8. Equipment and supplies

9. Instructor's guide
10. Student syllabus
11. References

Examination Modes

1. Response in classroom
2. Paper and pencil test
3. Rating on performance in simulated practice
4. Rating on performance in work situation (feedback)
5. Oral quiz on knowledge related to performance in simulated practice and/or work situation (feedback)

Training Time

- 0:30 hour didactic
- 0:30 hour supervised practice

LEARNING MODULE IQ3
CATHETERIZATION OF THE URINARY BLADDER

Tasks

- 330328 Cross check medications and treatment card with KARDEX and doctor's orders
- 110063 Verify identification of patient, e.g., for treatments, medications, and examinations
- 120080 Inform patient of procedures prior to/during examination/test/treatment
- 150078 Ask patient/check chart for contraindications for treatment/procedure/test
- 120010 Explain/answer patient's questions regarding examination/test/treatment/procedure
- 150141 Elicit information to ascertain patient's understanding of illness/treatment
- 120091 Explain/answer patient's questions regarding symptoms/disease/treatment
- 120046 Reassure/calm apprehensive/anxious patient
- _____ Wash hands prior to/after patient care, medications, treatments, examinations, procedure, specimen collecting and handling
- 110013 Drape/gown patient for treatment/examination
- 145044 Glove for sterile procedure
- 140200 Catheterize the urinary bladder, male
- 140201 Catheterize the urinary bladder, female
- 140280 Instill medication into tube, machine, e.g., tracheotomy tube, catheters, I.P.P.B. machine
- 130436 Evaluate patient's complaints/symptoms of pain
- 130382 Observe/record patient's physical/emotional response to treatment/diagnostic procedure
- 110010 Clean and clothe patient after surgery, treatment, examination
- 110096 Change patient's soiled linen and clothing
- 150013 Make suggestions regarding patient care
- 150082 Suggest changes in patient's nursing care plan
- 150102 Initiate and implement changes in patient's nursing care plan
- 150069 Give/receive verbal reports about patient
- 150035 Give report on changes/special care/treatments/tests for patient

150073 Notify medical personnel of treatment needs of patient

150064 Write nursing notes

_____ Record on patient's nursing care plan

Performance Objective (Stimulus)

When assigned by the doctor, nurse, or senior corpsman/technician to catheterize a patient as ordered by the physician.

Performance Objective (Behavior)

The corpsman/technician will verify the doctor's orders and patient's identity; inform the patient about the procedure, answer his questions, and reassure him; determine any contraindications for the procedure and notify the supervisory personnel; collect, check, and prepare the necessary equipment and supplies; position and drape the patient; wash hands and put on sterile gloves; clean and catheterize the patient; evaluate patient's condition and response to procedure; clean the patient, change clothing and/or linen if soiled; if indicated, suggest changes in nursing care and modify nursing care plan to reflect changes; and report to supervisory personnel and/or record on nursing notes the procedure, results of procedure, patient's condition and response to treatment.

Performance Objective (Conditions)

With selective supervision and with or without an assistant, depending on patient's condition.

Performance Objective (Criteria)

In accordance with established standard routines, procedures, and techniques.

Performance Objective (Consequence)

Patient's bladder will be emptied of urine.

Performance Objective (Next Action)

Make patient as comfortable as possible.

Knowledge and Skills

1. Purpose of catheterization
2. Anatomy and physiology of the urinary tract with emphasis on bladder and urethra
3. Communication techniques for giving information to and eliciting it from the patient and for reporting to supervisory personnel.
4. Observation techniques for assessing the patient's condition and response to catheterization and results of the catheterization.
5. Routine for verification of doctor's orders and patient's identity
6. Patient's diagnosis, therapy, and condition as related to the catheterization procedure.
7. Criteria for contraindications for catheterization
8. Procedures, techniques, and routines for catheterization and recording on the nursing notes and nursing care plan.
9. Precautionary measures relative to catheterization of the urinary bladder
10. Routines and techniques for suggesting changes in patient care and for modifying nursing care plan to reflect changes.
11. Routines and procedures for clean up and care of equipment

Instructional Strategies

1. Pretest and/or review on anatomy and physiology of the urinary tract; sterile technique; communication and observation skills; verification of doctor's orders and patient's identity; routines for reporting and recording.
2. Slides, filmstrips, films, videotapes, and/or mediated programmed instruction (individual or group) on purpose, procedure, techniques, and routines for catheterization of the urinary bladder.
3. Hardcover programmed instruction
4. Lecture
5. Discussion
6. Demonstration
7. Practice in simulated patient care unit
8. Practice in work situation
9. Study assignments
10. Written exercises

Training Aids

1. Filmstrips/films/videotapes
2. Mediated programmed instruction
3. Hardcover programmed instruction
4. Slides
5. Wall charts
6. Chalk board
7. Anatomical models
8. Equipment and supplies
9. Instructor's guide
10. Student syllabus
11. References

Examination Modes

1. Response in classroom
2. Paper and pencil test
3. Rating on performance in simulated practice
4. Rating on performance in work situation (feedback)
5. Oral quiz on knowledge related to performance in simulated practice and/or work situation (feedback)

Training Time

0:30 hour didactic

0:30 hour supervised practice

LEARNING MODULE IQ4
URINE SPECIMENS: COLLECTING AND HANDLING OF STERILE

Tasks

- 320328 Cross check medication and treatment card with KARDEX and doctor's orders
- 110063 Verify identification of patient, e.g., for treatment, medication, examination
- 120010 Explain/answer patient's questions regarding examination/test/treatment/procedure
- 150078 Ask patient/check chart for contraindications for treatment, procedure, test
- _____ Wash hands prior to/after patient care, medication, treatment, examination, procedure, specimen collecting and handling
- _____ Glove for sterile procedure
- _____ Collect sterile urine specimen
- 140200 Catheterize the urinary bladder, male
- 140201 Catheterize the urinary bladder, female
- 259005 Prepare, label, and send cultured specimen to the laboratory
- 130382 Observe and report patient's physical/emotional response to treatment/diagnostic procedure
- 130436 Evaluate patient's complaints or symptoms of pain
- 150064 Write nursing notes
- _____ Record on TPR graphic sheet

Performance Objective (Stimulus)

When assigned by the senior corpsman/technician, nurse, or doctor to collect and send a sterile urine specimen that was ordered by the doctor to the laboratory.

Performance Objective (Behavior)

The corpsman/technician will verify the doctor's orders and the patient's identity; explain the catheterization procedure to the patient and check for any contraindications; prepare the patient and set up for the catheterization; wash hands; put on sterile gloves; catheterize the patient or obtain

a sterile specimen from indwelling catheter; prepare, label, and send the specimen to the laboratory with proper laboratory request; record the procedure and specimen sent to the laboratory; and clean up and store equipment and leave the patient's unit tidy and clean and the patient in a comfortable position.

Performance Objective (Conditions)

With indirect supervision and with assistance, if indicated by patient's condition.

Performance Objective (Criteria)

In accordance with established standard procedure, maintaining sterile technique while collecting the specimen and sending proper amount of urine to laboratory.

Performance Objective (Consequence)

Sterile urine specimen collected and sent to the laboratory as ordered by the doctor.

Performance Objective (Next Action)

Follow-up on laboratory reports.

Knowledge and Skills

1. Anatomy and physiology of the urinary tract with emphasis on the bladder and urethra
2. Relationship of intake to output
3. Relationship of recent voiding to catheterization
4. Characteristics of normal urine and urinary tract abnormalities
5. Sterile technique for catheterization
6. Purpose of sterile urine specimen
7. Contraindications for the catheterization procedure
8. Routine and procedures for verification of doctor's orders and patient's identity

9. Patient's disease, therapy, and condition as related to catheterization procedure
10. Communication techniques for giving information to and eliciting it from the patient
11. Purpose of hand washing
12. Procedure, technique, and routine for gloving for sterile procedure
13. Procedures, techniques, and routines for obtaining catheterization tray, positioning, preparing for, and catheterizing the patient for a sterile urine specimen; labeling and attaching the laboratory form and sending to the laboratory.
14. Procedure and technique for obtaining sterile urine specimen from indwelling catheter.
15. Reporting to supervisory personnel any abnormal conditions and reactions of patient
16. Routine and procedure for recording procedure and specimen collection on patient's record and patient's nursing care plan.

Instructional Strategies

1. Pretest and/or review on anatomy and physiology of urinary tract; fluid balance; sterile technique; communication and observation skills; verification of doctor's orders and patient's identity; catheterization procedure; procedure for sending specimens to laboratory; routines for recording and reporting.
2. Slides, filmstrips, films, videotapes, and/or mediated programmed instruction (individual or group) on procedures, techniques, and routine for collecting sterile specimen during catheterization and from indwelling catheter.
3. Hardcover programmed instruction
4. Lecture
5. Discussion
6. Demonstration
7. Practice in simulated patient care unit
8. Practice in work situation
9. Study assignments
10. Written exercises

Training Aids

1. Filmstrips/films/videotapes
2. Mediated programmed instruction

3. Hardcover programmed instruction
4. Slides
5. Wall charts
6. Chalk board
7. Anatomical models
8. Equipment and supplies
9. Instructor's guide
10. Student syllabus
11. References

Examination Modes

1. Response in classroom
2. Paper and pencil test
3. Rating on performance in simulated practice
4. Rating on performance in work situation (feedback)
5. Oral quiz on knowledge related to performance in simulated practice and/or work situation (feedback)

Training Time

0:15 hour didactic	(May be combined with Learning Module IQ3,
0:15 hour supervised practice	"Catheterization of the Urinary Bladder")

LEARNING MODULE IQ5
URINARY GRAVITY AND DECOMPRESSION DRAINAGE

Tasks

- 330328 Cross check medication and treatment card with KARDEN and doctor's orders
- 110063 Verify identification of patient, e.g., for treatments, medications, and examinations
- 120080 Inform patient of procedures prior to/during examination/test/treatment
- 150078 Ask patient/check chart for contraindications for treatment/procedure/test
- 120010 Explain/answer patient's questions regarding examination/test/treatment/procedure
- 120091 Explain/answer patient's questions regarding symptoms/disease/treatment
- 150141 Elicit information to ascertain patient's understanding of illness/treatment
- 120046 Reassure/calm apprehensive/anxious patient
- _____ Wash hands prior to/after patient care, medications, treatments, examinations, procedures, specimen collecting and handling
- 110013 Drape/gown patient for treatment/examination
- 145044 Glove for sterile procedure
- 140358 Give Foley catheter, e.g., clean meatus, clamp tube, use leg bag
- 140280 Instill medication into tube, machine, e.g., tracheotomy tube, catheters, I.P.P.B. machine
- 140152 Remove Foley catheter
- 140357 Perform tidal drainage
- _____ Maintain and give care to patients with cystostomy, nephrostomy, and ureterostomy drainage tubes
- _____ Maintain and give care to patients with ureteral transplant drainage, e.g., ureterosigmoid, cutaneous, ureterodial
- 130436 Evaluate patient's complaints/symptoms of pain
- 130382 Observe/record patient's physical/emotional response to treatment/diagnostic procedure
- 110010 Clean and clothe patient after surgery, treatment, examination
- 110096 Change patient's soiled linen and clothing
- 150013 Make suggestions regarding patient care
- 150082 Suggest changes in patient's nursing care plan

- 150102 Initiate and implement changes in patient's nursing care plan
- 150069 Give/receive verbal reports about patient
- 150035 Give report on changes/special care/treatments/tests for patient
- 150073 Notify medical personnel of treatment needs of patient
- 150064 Write nursing notes
- _____ Record on patient's nursing care plan

Performance Objective (Stimulus)

When assigned by the doctor, nurse, or senior corpsman/technician to initiate, maintain, and terminate urinary tract drainage systems ordered by the physician.

Performance Objective (Behavior)

The corpsman/technician will verify the doctor's orders and patient's identity; inform the patient about the procedure, answer his questions, and reassure him; determine any contraindications for the procedure and notify the supervisory personnel; collect, check, and prepare the required equipment and supplies; initiate, maintain, and terminate ureteral catheter drainage and instill medications as ordered; maintain and give care required for cystostomy, nephrostomy, and ureterostomy drainage tubes; maintain and give care for ureteral transplant drainage via sigmoid, ileum, and skin; clean patient and change clothing and linen as required after care; if indicated, suggest changes in nursing care and modify nursing care plan to reflect changes; and report to supervisory personnel and/or record on nursing notes the procedures, results of procedure, amount of drainage, and patient's condition and/or response to the procedure.

Performance Objective (Conditions)

With selective supervision and with or without assistance, depending on patient's condition.

Performance Objective (Criteria)

In accordance with established standard routines, procedures, and techniques.

Performance Objective (Consequence)

Maintenance of urinary outputs and prevention of infection.

Performance Objective (Next Action)

Make the patient as comfortable as possible.

Knowledge and Skills

1. Purpose of different types of urinary drainage systems and bladder instillations
2. Anatomy and physiology of urinary tract
3. Communication techniques for giving information to and eliciting it from the patient and for reporting to supervisory personnel.
4. Observation techniques for assessing the patient's condition and response to the type of urinary drainage system installed; the amount and characteristics of the drainage; and the signs and symptoms of infection.
5. Routine for verification of doctor's orders and patient's identity
6. Patient's diagnosis, therapy, and condition as related to the functioning and care of his urinary drainage system.
7. Criteria for contraindications for initiating urethral drainage systems and giving care for all types of urinary drainage systems.
8. Procedures, techniques, and routines for initiating, maintaining, and terminating urethral drainage systems; maintaining and caring for cystostomy, nephrostomy, and ureterostomy drainage tubes and ureteral transplant drainage tubes; giving bladder instillations via indwelling catheters; and recording on the nursing notes and nursing care plan.
9. Precautionary measures relative to initiating urethral drainage systems; instilling drugs into the bladder; disconnecting the indwelling catheter; and skin care around suprapubic drainage tubes and transplant fistulas.
10. Routines and techniques for suggesting changes in patient care and for modifying nursing care plan to reflect changes.
11. Routines and procedures for clean up and care of equipment

Instructional Strategies

1. Pretest and/or review on anatomy and physiology of the urinary tract; sterile technique; communication and observation skills; verification of doctor's orders and patient's identity; routines for reporting and recording.
2. Slides, filmstrips, films, videotapes, and/or mediated programmed instruction (individual or group) on purpose, procedures, techniques, and routines for initiating, maintaining, and terminating urethral drainage systems; giving care to patients with suprapubic urinary drainage tubes and ureteral, transplant drainage; instilling drugs via indwelling catheter into the bladder

3. Hardcover programmed instruction
4. Lecture
5. Discussion
6. Demonstration
7. Practice in simulated patient care unit
8. Practice in work situation
8. Study assignments
9. Written exercises

Training Aids

1. Filmstrips/films/videotapes
2. Mediated programmed instruction
3. Hardcover programmed instruction
4. Slides
5. Wall charts
6. Chalk board
7. Anatomical models
8. Equipment and supplies
9. Instructor's guide
10. Student syllabus
11. References

Examination Modes

1. Response in classroom
2. Paper and pencil test
3. Rating on performance in simulated practice
4. Rating on performance in work situation (feedback)
5. Oral quiz on knowledge related to performance in simulated practice and/or work situation (feedback)

Training Time

1:00 hour didactic

1:00 hour supervised practice

LEARNING MODULE IQ6
URINARY TRACT IRRIGATIONS

Tasks

- 330328 Cross check medication and treatment card with KARDEX and doctor's orders
- 110063 Verify identification of patient, e.g., for treatment, medications, examination
- 120080 Inform patient of procedure prior to/during examination/test/treatment
- 150078 Ask patient/check chart for contraindications for treatment/procedure/test
- 120010 Explain/answer patient's questions regarding examination/test/treatment/procedure
- 120091 Explain/answer patient's questions regarding symptoms/disease/treatment
- 150141 Elicit information to ascertain patient's understanding of illness/treatment
- 120046 Reassure/calm apprehensive/anxious patient
- _____ Wash hands prior to/after patient care, medications, treatments, examinations, procedures, specimen collecting/handling
- 140114 Irrigate the bladder or administer bladder instillations via Foley catheter
- 140354 Irrigate suprapubic tube
- 140353 Irrigate ureterostomy tube, suprapubic tube, and Foley catheter
- 140356 Maintain continuous bladder irrigations
- 130436 Evaluate patient's complaints/symptoms of pain
- 130382 Observe/record patient's physical/emotional response to treatment/diagnostic procedure
- 110010 Clean and clothe patient after surgery, treatment, examination
- 110096 Change patient's soiled linen and clothing
- 150013 Make suggestions regarding patient care
- 150102 Initiate and implement changes in patient's nursing care plan
- 150069 Give/receive verbal reports about patient
- 150035 Give report on changes/special care/treatment/tests for patient
- 150073 Notify medical personnel of treatment needs of patient
- 150064 Write nursing notes
- _____ Record on patient's nursing care plan

Performance Objective (Stimulus)

When assigned by the doctor, nurse, or senior corpsman/technician to perform irrigations of the urinary tract and to administer bladder instillations.

Performance Objective (Behavior)

The corpsman/technician will verify the doctor's orders and patient's identity; inform the patient about the procedure, answer his questions, and reassure him; determine any contraindications for the procedure and notify the supervisory personnel; collect, check, and prepare the necessary equipment and supplies; position and drape the patient; wash his hands; irrigate the bladder by Foley catheter; irrigate ureterostomy tube and other suprapubic tubes; maintain continuous irrigations; perform bladder instillations; evaluate patient's condition and response to the procedure; clean the patient and change clothing and/or linen if soiled; if indicated, suggest changes in nursing care and modify nursing care plan to reflect the changes; and report to supervisory personnel and record on nursing notes the procedure, results of procedure, patient's condition, and response to treatment.

Performance Objective (Conditions)

With indirect supervision and without assistance.

Performance Objective (Criteria)

In accordance with established standard routines, procedures, and techniques.

Performance Objective (Consequence)

Prescribed urinary tract irrigations and instillations will be made.

Performance Objective (Next Action)

Make the patient as comfortable as possible.

Knowledge and Skills

1. Purpose of different types of urinary tract irrigations
2. Anatomy and physiology of urinary tract and bladder instillations

3. Communication techniques for giving information to and eliciting information from the patient and for reporting to supervisory personnel.
4. Observation techniques for assessing the patient's condition and response to the type of urinary tract irrigation administered and the signs and symptoms of infection.
5. Routine for verification of doctor's orders and patient's identity
6. Patient's diagnosis, therapy, and condition as related to the type of irrigation administered and to bladder instillations.
7. Criteria for contraindications for performing the prescribed urinary tract irrigation and/or the bladder instillation.
8. Procedures, techniques, and routines for performing different types of urinary tract irrigations and instilling solutions into the bladder and recording on the nursing notes and nursing care plan.
9. Precautionary measures relative to sterile technique and the force of the irrigation.
10. Routines and techniques for suggesting changes in patient care and for modifying nursing care plan to reflect changes.
11. Routines and procedures for clean up and care of equipment

Instructional Strategies

1. Pretest and/or review on anatomy and physiology of the urinary tract; sterile technique; communication and observation skills; verification of doctor's orders and patient's identity; routines for reporting and recording.
2. Slides, filmstrips, films, videotapes, and/or mediated programmed instruction (individual or group) on purpose, procedures, techniques, and routines for giving bladder and other urinary irrigations and bladder instillations.
3. Hardcover programmed instruction
4. Lecture
5. Discussion
6. Demonstration
7. Practice in simulated patient care unit
8. Practice in work situation
9. Study assignments
10. Written exercises

Training Aids

1. Filmstrips/films/videotapes
2. Mediated programmed instruction
3. Hardcover programmed instruction
4. Slides
5. Wall charts
6. Chalk board
7. Anatomical models
8. Equipment and supplies
9. Instructor's guide
10. Student syllabus
11. References

Examination Modes

1. Response in classroom
2. Paper and pencil test
3. Rating on performance in simulated practice
4. Rating on performance in work situation (feedback)
5. Oral quiz on knowledge related to performance in simulated practice and/or work situation (feedback)

Training Time

- 0:30 hour didactic
- 0:30 hour supervised practice

LEARNING MODULE IQ7

URINARY TRACT DIAGNOSTIC TESTS AND EXAMINATIONS: PREPARATIONS FOR

Tasks

- 330328 Cross check medications and treatment care with KARDEX and doctor's orders
- 110063 Verify identification of patient, e.g., for treatments, medications, and examinations
- 120080 Inform patient of procedures prior to/during examination/test/treatment
- 150078 Ask patient/check chart for contraindications for treatment/procedure/test
- 120010 Explain/answer patient's questions regarding examination/test/treatment/procedure
- 120091 Explain/answer patient's questions regarding symptoms/disease/treatment
- 150141 Elicit information to ascertain patient's understanding of illness/treatment
- 120046 Reassure/calm apprehensive/anxious patient
- 130436 Evaluate patient's complaints/symptoms of pain
- 130382 Observe/record patient's physical/emotional response to treatment/diagnostic procedure
- _____ Prepare patient for X-ray examinations of urinary tract, e.g., intravenous urogram, retrograde pyelogram, aortography
- 120018 Explain X-ray to the patient
- 330143 Place special treatment tag over/on bed, e.g., fasting, force fluids
- 150142 Ascertain that patient has been prepped for test/treatment/examination
- 150069 Give/receive verbal reports about patient
- 150035 Give report on changes/special care/treatments/tests for patient
- 150064 Write nursing notes
- _____ Record on patient's nursing care plan

Performance Objective (Stimulus)

When assigned by the doctor, nurse, senior corpsman/technician to prepare the patient for X-ray examinations of the urinary tract prescribed by the physician.

Performance Objective (Behavior)

The corpsman/technician will verify the doctor's orders and patient's identity; inform the patient about the examination and the preparation for it, answer his questions, and reassure him; determine any contraindications (especially allergies to shell fish type of food) and notify the supervisory personnel; carry out the standard orders for preparation for intravenous urogram, retrograde pyelogram, and aortography, unless otherwise ordered by the doctor; mark patient's bed for special examination; report to supervisory personnel and/or record on nursing notes each step of preparation procedure as completed; ascertain patient is prepared prior to transporting for examination; and record on nursing notes and nursing care plan examination which patient received.

Performance Objective (Conditions)

With indirect supervision and without assistance.

Performance Objective (Criteria)

According to established standard routines, procedures, and techniques.

Performance Objective (Consequence)

Patient will be prepared for the urinary tract X-ray examination ordered by the physician.

Performance Objective (Next Action)

Follow-up on X-ray examination report.

Knowledge and Skills

1. Purpose of urinary tract X-ray examination; intravenous urogram, retrograde pyelogram, and aortography.
2. Anatomy and physiology of urinary tract and related circulatory system
3. Communication techniques for giving information to and eliciting it from the patient and for reporting to supervisory personnel.
4. Preparatory steps for the examination
5. Routine for verification of doctor's orders and patient's identity

6. Patient's diagnosis, therapy, and condition as related to ordered examination and preparation for it.
7. Criteria for contraindications for ordered examination and preparation for it
8. Procedures, techniques, and routines for preparing patient for intravenous urogram, retrograde pyelogram, and aortography and recording on the nursing notes and nursing care plan.
9. Precautionary measures relative to preparation for ordered urinary tract X-ray examination.
10. Routines and techniques for suggesting changes in patient care and for modifying nursing care plan to reflect changes.
11. Routines and procedures for clean up and care of equipment

Instructional Strategies

1. Pretest and/or review on anatomy and physiology of urinary tract; communication and observation skills; routines for reporting and recording.
2. Slides, filmstrips, films, videotapes, and/or mediated programmed instruction (individual or group) on purpose, procedure, techniques, and routines for preparation of patient for intravenous urogram, retrograde pyelogram, and aortography.
3. Hardcover programmed instruction
4. Lecture
5. Discussion
6. Demonstration
7. Practice in simulated patient care unit
8. Practice in work situation
9. Study assignments
10. Written exercises

Training Aids

1. Filmstrips/films/videotapes
2. Mediated programmed instruction
3. Hardcover programmed instruction
4. Slides
5. Wall charts
6. Chalk board

7. Anatomical models
8. Equipment and supplies
9. Instructor's guide
10. Student syllabus
11. References

Examination Modes

1. Response in classroom
2. Paper and pencil test
3. Rating on performance in simulated practice
4. Oral quiz on knowledge related to performance in simulated practice and/or work situation (feedback)

Training Time

0:30 hour didactic

LEARNING MODULE IQ8

URINE SPECIMENS: COLLECTING AND HANDLING OF URINE FOR SPECIAL TESTS

Tasks

- 320328 Cross check medication and treatment card with KARDEX and doctor's orders
- 110063 Verify identification of patient, e.g., for treatment, medications, examination
- 120080 Inform patient of procedure prior to/during examination/test/treatment
- 120010 Explain/answer patient's questions regarding examination/test/treatment/procedure
- 330143 Place special treatment tag over/on bed, e.g., fasting, force fluids
- 150078 Ask patient/check chart for contraindications of treatment/procedure/test
- 150142 Ascertain that patient has been prepped for test/treatment/procedure
- 120131 Ask patient to collect specimen
- _____ Wash hands prior to/after patient care, medication, treatment, examination, procedure, specimen collecting and handling
- 120132 Check with patient to ensure that he has collected specimens as instructed
- 259947 Collect timed specimen such as 24-hour urine for glucose tolerance
- _____ Collect urine specimen for urobilinogen test and send to laboratory
- _____ Collect urine specimen for Addis sediment count and send to laboratory
- _____ Collect urine specimen for Fishberg concentration test and send to laboratory
- _____ Collect urine specimen for Mosenthal/modified Mosenthal test and send to laboratory
- _____ Collect urine specimen for phenolsulfonphthalein test and send to laboratory
- _____ Prepare, label, and send emergency specimens to the laboratory
- 130382 Observe and record patient's physical/emotional response to treatment/diagnostic procedures
- 130436 Evaluate patient's complaints or symptoms of pain
- 150064 Write nursing notes
- _____ Record on TPR graphic sheet
- _____ Check off on patient's nursing care plan

Performance Objective (Stimulus)

When assigned by the senior corpsman/technician, nurse, or doctor to collect and send urine specimens for special tests, ordered by the doctor to the laboratory.

Performance Objective (Behavior)

The corpsman/technician will verify the specimens to be collected and the identity of the patient from whom it is to be collected; explain to the patient the requirement for the specimen, how it is to be collected, and evaluate his understanding of the communication; ascertain any contraindications for the test; ascertain that patient has been prepared for the test as required; wash hands; collect, prepare, label, attach laboratory request, and send to the laboratory urine specimen for glucose tolerance, urobilinogen, Addis sediment, Mosenthal, modified Mosenthal, Fishberg concentration, and phenolsulfonphthalein routine or emergency tests; evaluate the patient's complaints and reaction to the collection procedure; and record on nursing notes, TPR graphic sheet, and patient's nursing care plan.

Performance Objective (Conditions)

With selective supervision and without assistance.

Performance Objective (Criteria)

In accordance with established standard procedures and practices and without time error in administering drugs as related to specimen collection, in collecting interrupted specimens, and in sending properly labeled specimen with laboratory request form to laboratory.

Performance Objective (Consequence)

Urine specimens sent to the laboratory for special tests as ordered by the doctor.

Performance Objective (Next Action)

Follow-up on laboratory report.

AD-A085 706

TECHNOMICS INC OAKTON VA

A SYSTEM APPROACH TO NAVY MEDICAL EDUCATION AND TRAINING. APPEN--ETC(11)

F/S B/S

N00014-69-C-0246

NL

UNCLASSIFIED

7 14 7

7-80

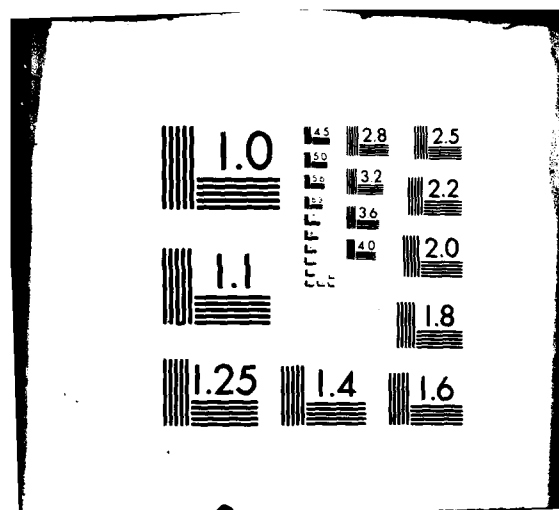
END

DATE

FILED

7-80

DTIC



Knowledge and Skills

1. Anatomy and physiology of the urinary tract
2. Relationship of intake to output
3. Characteristics of normal urine and urinary tract abnormalities
4. Nature and significance of the tests
5. Contraindications for the tests
6. Routines and procedures for verification of doctor's orders and patient's identity
7. Patient's disease, therapy, and condition as related to the test
8. Communication techniques for giving information to and eliciting it from the patient prior to and during the procedure.
9. Instructions to the patient on preparation for test and on the collection routine and procedures.
10. Purpose of hand washing
11. Procedures and techniques for preparing the patient, such as food, force or restrict fluids, and administration of medication; timing specimen collection; proper containers labeled correctly; and sending to laboratory with correct laboratory form.
12. Reporting to the supervisor progress of collection
13. Procedure and techniques for recording on patient's record and patient's nursing care plan.

Instructional Strategies

1. Pretest and/or review on verification of doctor's orders and patient's identity; communication, observation, and instructional skills; procedures for preparing and sending specimens to laboratory and recording.
2. Slides, filmstrips, films, videotapes, and/or mediated programmed instruction (individual or group) on procedures and techniques for collecting urine specimens for 24-hour glucose tolerance and Vanlmandeler acid, urobilinogen, Addis sediment, Fishberg concentration, phenolsulfonphthalein and Mosenthal or modified Mosenthal tests.
3. Hardcover programmed instruction
4. Lecture
5. Demonstration
6. Discussion
7. Study assignments
8. Written exercises

Training Aids

1. Filmstrips/films/videotapes
2. Mediated programmed instruction
3. Hardcover programmed instruction
4. Chalk board
5. Equipment and supplies
6. Instructor's guide
7. Student syllabus
8. References

Examination Modes

1. Response in classroom
2. Paper and pencil test
3. Rating on performance in simulated practice
4. Rating on performance in work situation (feedback)
5. Oral quiz on knowledge related to performance in simulated practice and/or work situation (feedback)

Training Time

1:00 hour didactic

LEARNING MODULE IQ9
URINE TEST: PERFORMED IN PATIENT CARE UNIT

Tasks

- 320328 Cross check medication and treatment card with KARDEX and doctor's orders
- 110063 Verify identification of patient, e.g., for treatment, medications, examination
- 120010 Explain/answer patient's questions regarding examination/test/treatment/procedure
- 150078 Ask patient/check chart for contraindications of treatment/procedure/test
- 120131 Ask patient to collect specimen
- 120132 Check with patient to ensure that he has collected the specimen as instructed
- 250026 Check specific gravity of urine
- 251001 Check urine pH by paper strip/dipstick
- 251002 Check urine sugar by dipstick/clinittest
- 251003 Check urine protein by dipstick
- 251005 Check urine acetone/ketone bodies
- 150064 Write nursing notes
- _____ Record on special forms, e.g., Diabetic Flow Chart
- _____ Wash hands prior to/after patient care, medication, treatment, examination, procedure, specimen collecting and handling

Performance Objective (Stimulus)

When assigned by the senior corpsman/technician, nurse, or doctor to test a patient's urine for sugar, protein, acetone or ketone bodies, pH, and specific gravity, as ordered by the doctor.

Performance Objective (Behavior)

The corpsman/technician will verify the doctor's orders and patient's identity; explain to the patient the requirement for the specimen and ascertain that he collects it correctly; test the urine specimen for sugar, protein, acetone or ketone bodies, specific gravity and pH; wash hands; report abnormal findings

to his supervisor; record on nursing notes and other special records, such as Diabetic Flow Chart; clean and store equipment and clean and tidy testing area.

Performance Objective (Conditions)

With indirect supervision and without assistance using the appropriate controls, standards, reagents, and color chart.

Performance Objective (Criteria)

Performed according to standard laboratory procedure, control values in accepted range, and procedural standards.

Performance Objective (Consequence)

Quantification of sugar, acetone and ketone bodies, pH, specific gravity, and protein.

Performance Objective (Next Action)

Report abnormal results to supervisor and record results on the patient's record.

Knowledge and Skills

1. Normal range of each test result
2. Sources of error in each test
3. Special color for each reagent for sugar testing
4. Special care of reagents
5. Patient's disease, therapy, and condition
6. Verification of doctor's orders and patient's identity
7. Communication techniques to give information to and elicit it from the patient
8. Procedures and techniques for doing tests
9. Purpose of hand washing
10. Procedure for reporting and recording
11. Clean and store equipment, have testing area clean and tidy

Instructional Strategies

1. Pretest and/or review on routines for verification of doctor's orders and patient's identity; communication, observation, and instructional skills.
2. Slides, filmstrips, films, videotapes, and/or mediated programmed instruction (individual or group) on procedures, techniques, and routines for performing tests of urine for sugar, protein, acetone or ketone bodies, specific gravity, and pH.
3. Hardcover programmed instruction
4. Lecture
5. Discussion
6. Demonstration
7. Practice in simulated patient care unit
8. Practice in work situation
9. Study assignments
10. Written exercises

Training Aids

1. Filmstrips/films/videotapes
2. Mediated programmed instruction
3. Hardcover programmed instruction
4. Slides
5. Color charts for each sugar test technique
6. Chalk board
7. Equipment and supplies
8. Instructor's guide
9. Student syllabus
10. References

Examination Modes

1. Response in classroom
2. Paper and pencil test
3. Rating on performance in simulated practice

4. Rating on performance in work situation (feedback)
5. Oral quiz on knowledge related to performance in simulated practice and/or work situation (feedback)

Training Time

1:00 hour didactic

1:00 hour supervised practice

TRAINING UNIT IR
CARE OF THE SURGICAL PATIENT

Learning Modules

- IR1. Surgical Wounds: Observation and Examination of Dressings
- IR2. Preoperative Preparation of the Patient
- IR3. Postoperative Unit: Preparation of
- IR4. Patient Care: Postoperative
- IR5. Surgical Wounds: Changing Dressings
- IR6. Surgical Wounds: Packing and Drains
- IR7. Surgical Wounds: Irrigations
- IR8. Surgical Wounds: Suture Removal

Training Objective

Upon completion of this training unit, the learner must be able to observe, report, and record the condition of surgical dressings; prepare the patient for the surgical procedure ordered by the physician; set up the postoperative unit ready for the patient's return from surgery; receive the patient from surgery and give care and prescribed medications and treatments; change surgical dressings; shorten and/or remove drains; remove and insert packing into wounds; irrigate wounds; and remove sutures.

According to the requirements for the care, medications, treatments, and procedures, the learner must be able to verify the doctor's orders and patient's identity; follow routines according to established procedure; inform the patient about the care, medications, treatments, and procedures and answer his questions and reassure him; determine any contraindications for care, medications, treatments, and procedures and notify the supervisory personnel; check, collect, and prepare the required equipment and supplies; position and drape the patient; scrub or wash his hands; give the care, medication, treatment, or procedure; clean the patient and change his clothing and linen, if necessary; if indicated, suggest changes in patient care and modify the nursing care plan to reflect the changes; report to his supervisor as required the patient's condition, treatment given or procedure performed, the results of it, and the patient's response

to it; and record the foregoing information on the nursing notes and other appropriate records and check off on the nursing care plan.

The learner must be able to accomplish the foregoing with indirect and selective supervision and with or without assistance, depending upon the patient's condition. He must be able to perform the foregoing according to established standard routines, procedures, and techniques.

The patient preoperatively and postoperatively will receive the care and the prescribed medications and treatments as scheduled; will be monitored closely on return from surgery; and, as required, will have his wound dressed and irrigated, drains and packing adjusted or removed, and sutures removed.

Knowledge and Skills

1. Purpose and objectives of preoperative and postoperative care, medications, treatments, and procedures; examination of dressings; application of binders, bandages, and strapping; changing of surgical dressings; irrigation of wounds; shortening and removal of drains; packing of incisions, wounds, and cavities; and removal of sutures.
2. Anatomy and physiology as related to prescribed surgery, surgical wounds, healing process, hemorrhage, infection, and drainage.
3. Sterile techniques as related to surgical wounds; intravenous infusions and transfusions, and indwelling catheters.
4. Communication techniques for giving information to and eliciting it from the patient and reporting to supervisory personnel.
5. Observation techniques for assessing maintenance of sterility, wounds' condition, patient's condition and response to treatment and care.
6. Routine for verification of doctor's orders and patient's identity
7. Patient's diagnosis, therapy, condition, and type of surgery as related to preoperative, postoperative, and wound care.
8. Criteria for determining any contraindications to care, medications, treatment, and procedures.
9. Procedure, techniques, and routines for preparing the patient for surgery; preparing the postoperative unit; giving postoperative care; changing surgical dressings; irrigating surgical wounds; shortening and removing wound drains; packing incisions, wounds, and cavities; removing sutures; applying binders, bandages, and strapping; and observing and examining dressing.
10. Precautionary measures relative to preoperative skin preparation; insertion of catheters and nasogastric tubes; postoperative monitoring; surgical wound care; and administration of medications.

11. Routines and techniques for suggesting changes in patient care and modifying nursing care plan to reflect changes.
12. Routine and procedures for recording on nursing notes and nursing care plan
13. Routines for clean up and care of equipment

Instructional Strategies

1. Pretest and/or review on communication and observation skills; anatomy and physiology as related to surgical wounds, healing, hemorrhage, infection, drainage and to support of injured parts of the body; giving of general patient care; administration of medications; giving an enema; inserting of catheters and nasogastric tubes; maintenance of open or closed drainage with or without suction; taking vital signs; giving oxygen; monitoring intravenous infusions and transfusions; recording intake and output and application of binders, bandages, and strapping; routine for verification of doctor's orders and patient's identity; routine for reporting on patient's condition and recording in official records.
2. Slides, filmstrips, films, videotapes, and/or mediated programmed instruction (individual or group) on procedures, techniques, and routines for preparing the patient for surgery; preparing the postoperative unit and giving care to the postoperative patient; changing surgical dressings, including irrigating wounds, shortening and removing drains from wounds, packing incisions, wounds, and cavities, removing sutures, applying binders, bandages and straps, and observing and examining dressing; contraindications and precautionary measures related to each procedure.
3. Hardcover programmed instruction
4. Lecture
5. Discussion
6. Demonstration
7. Role playing
8. Practice in simulated patient care unit
9. Practice in work situation
10. Study assignments
11. Written exercises
12. Problem solving situations

Training Aids

1. Filmstrips/films/videotapes
2. Mediated programmed instruction

3. Hardcover programmed instruction
4. Slides
5. Chalk board
6. Anatomical models
7. Equipment and supplies
8. Instructor's guide
9. Student syllabus
10. References

Examination Modes

1. Response in classroom
2. Paper and pencil test
3. Rating on performance in simulated practice
4. Rating on performance in work situation (feedback)
5. Oral quiz on knowledge related to performance in simulated practice and/or work situation (feedback)

Training Time

7:00 hours didactic

8:45 hours supervised practice

LEARNING MODULE IR1
SURGICAL WOUNDS: OBSERVATION AND EXAMINATION OF DRESSINGS

Tasks

- 320328 Cross check medication and treatment card with KARDEX and doctor's orders
- 110063 Verify identification of patient, e.g., for treatment, medication, examination
- 120080 Inform patient of procedure prior to/during examination/test/treatment
- 150078 Ask patient/check chart for contraindication for treatment/procedure/test
- 120046 Reassure/calm apprehensive/anxious patient
- _____ Wash hands prior to/after patient care, medication, treatment, examination, procedure, specimen collecting and handling
- 130007 Check dressings, e.g., cleanliness
- 130259 Check for/report symptoms of wound infection
- 130424 Observe/record or describe characteristics of drainage from incisions and wounds
- 130271 Observe for symptoms of external hemorrhage
- 130073 Estimate and record blood loss following hemorrhage
- 130436 Evaluate patient's complaints/symptoms of pain
- 130382 Observe/record patient's physical/emotional response to treatment/diagnostic procedure
- 150036 Inform doctor/nurse of patient's condition, e.g., description of symptoms, injuries, or response
- 150064 Write nursing notes
- _____ Record on patient's nursing care plan

Performance Objective (Stimulus)

When assigned by the senior corpsman/technician, nurse, or doctor to observe and examine surgical dressings in accordance with the doctor's orders.

Performance Objective (Behavior)

The corpsman/technician will verify the identity of the patients who have surgical dressings; communicate with the patients about the dressing and reassure anyone who is apprehensive about his wound; be aware of any

contraindications in examining the dressing such as moving the patient; wash hands; check the dressing for cleanliness and drainage; describe the kind of drainage--blood, serosanguineous, pus-like, etc., and the amount--dressing saturated, slightly stained, etc.; evaluate the patient's condition and report to supervisory personnel; and record on nursing notes and nursing care plan.

Performance Objective (Conditions)

With indirect supervision and without assistance, except when an assistant is required to aid in moving the patient for dressing examination.

Performance Objective (Criteria)

In accordance with established standard procedures, techniques, and routines for examining, describing, and reporting condition of wound dressings.

Performance Objective (Consequence)

Current information on the status of patient's dressings.

Performance Objective (Next Action)

Reinforce dressing in cases of heavy drainage, hemorrhage, and/or loosening and make the patient as comfortable as possible and notify supervisor.

Knowledge and Skills

1. Purpose of dressings, kinds of dressings
2. Anatomy and physiology as related to hemorrhage, infection, and drainage from wounds
3. Communication techniques for giving information to and eliciting it from the patient and reporting to supervisory personnel.
4. Routine for verification of doctor's orders and patient's identity
5. Patient's diagnosis, therapy, and surgical procedure
6. Criteria for determining contraindications for method of examining patient's dressing.
7. Precautionary measures in examining dressing
8. Observation techniques for assessing the condition of the patient's dressing: security of attachment, cleanliness, amount of hemorrhage, amount of drainage; and the patient's general condition and response to dressing examination.

9. Routine for recording observations on nursing notes and nursing care plan
10. Routine for suggesting changes in patient care and modifying nursing care plan accordingly.

Instructional Strategies

1. Pretest and/or review on communication and observation skills; anatomy and physiology as related to wound hemorrhage, infection and drainage; routine for verification of doctor's orders and patient's identity; routine for recording procedure on nursing notes and nursing care plan; routine for reporting findings.
2. Slides, filmstrips, films, videotapes, and/or mediated programmed instruction (individual or group) on purpose of dressings, kinds of dressings, security of dressings, normal and abnormal appearance of dressings.
3. Hardcover programmed instruction
4. Lecture
5. Discussion
6. Demonstration
7. Practice in simulated patient care unit
8. Practice in work situation
9. Study assignments
10. Written exercises

Training Aids

1. Filmstrips/films/videotapes
2. Mediated programmed instruction
3. Hardcover programmed instruction
4. Slides
5. Chalk board
6. Anatomical models
7. Equipment and supplies
8. Instructor's guide
9. Student syllabus
10. References

Examination Modes

1. Response in classroom
2. Paper and pencil test
3. Rating on performance in simulated practice
4. Rating on performance in work situation (feedback)
5. Oral quiz on knowledge related to performance in simulated practice and/or work situation (feedback)

Training Time

0:45 hour didactic

0:30 hour supervised practice

LEARNING MODULE IR2
PREOPERATIVE PREPARATION OF THE PATIENT

Tasks

- 330328 Cross check medication and treatment card with KARDEX and doctor's orders
- 110063 Verify identification of patient, e.g., for treatment, medications, examination
- 120090 Explain minor surgical procedures/operation to patient/family
- 120010 Explain/answer patient's questions regarding examination/test/treatment/procedure
- 120091 Explain/answer patient's questions regarding symptoms/disease/treatment
- 150078 Ask patient/check chart for contraindications for treatment/procedure/test
- 150141 Elicit information to ascertain patient's understanding of illness/treatment
- 120046 Reassure/calm apprehensive/anxious patient
- 320327 Witness/ensure patient's consent/permission has been obtained for treatment/examination/release
- 110099 Assist patient in religious rites, e.g., praying, reading scriptures
- 110050 Remove, secure, return patient's personal effects
- 120038 Teach patient breathing exercises
- 120316 Teach patient to cough and deep breathe
- 140071 Give enema
- 110023 Give bed bath to patient
- 110027 Assist patient with tub, sitz bath, or shower
- 110028 Groom patient, e.g., shampoo, comb hair, give toenail and fingernail care, shave beard
- 110044 Shave and scrub patient for surgery or delivery room or treatment or examination
- 110025 Give phisoex/betadine scrub to patient
- 110085 Give oral medications
- 330143 Place special treatment tags over/on bed, e.g., fasting, force fluids
- _____ Wash patient's face and hands
- 110094 Give or help patient with oral hygiene, e.g., brush teeth, clean dentures, mouthwash

140358 Give Foley catheter, e.g., clean meatus, clamp tube, use leg bag
140214 Insert/remove nasogastric tube/Levine tube
_____ Insert/remove Miller-Abbott tube
_____ Insert/remove Abbott-Rawson tube
140011 Administer subcutaneous medications
150142 Ascertain that patient has been prepped for test/treatment/procedure
330487 Complete and verify preoperative check-off list
110015 Assist patient in putting on clothes .
150069 Give/receive verbal reports about patient
150035 Give report on changes/special care/treatment/tests for patient
150064 Write nursing notes
_____ Record on patient's nursing care plan

Performance Objective (Stimulus)

When assigned by the doctor, nurse, or senior corpsman/technician to prepare a patient for surgery as ordered by the physician.

Performance Objective (Behavior)

The corpsman/technician will verify the doctor's orders and the patient's identity; inform the patient about his preparation for surgery, answer his questions, and reassure him; note any contraindications for the preparation and allergies; ensure that patient's permission for anesthesia and surgery is obtained; ensure that patient has been seen by the chaplain; remove, record, and store his valuables; teach the patient breathing exercises, including deep breathing and coughing; give cleansing enema; ensure that the patient receives a bath, shampoo if needed, shave, nail care, and oral hygiene; shave and scrub the operative site; give ordered medications; have patient void or insert indwelling catheter; insert nasogastric tubes; clothe the patient for surgery and ensure that patient's records, including surgical check-off list, are completed; and inform supervisor of progress of the preparation.

Performance Objective (Conditions)

With indirect supervision and with or without assistance, depending upon patient's condition.

Performance Objective (Criteria)

According to established standard procedures, techniques, and routines for prescribed surgery.

Performance Objective (Consequence)

Patient is properly prepared for transfer to the operating room with current records and X-rays.

Performance Objective (Next Action)

Prepare the postoperative unit for patient's return from surgery.

Knowledge and Skills

1. Purpose of each step in the preoperative preparation
2. Preoperative preparation time schedule--what needs to be done day before surgery and day of surgery.
3. Communication techniques for giving information to and eliciting information from the patient and for reporting to supervisory personnel.
4. Observation techniques for assessing the patient's condition and response to each step of the preparation and to the surgical procedure.
5. Routine for verification of doctor's orders and patient's identity
6. Patient's diagnosis, therapy, and condition as related to preparation for surgery and to surgical procedure.
7. Criteria for contraindications for any step in the preparation routine, including allergic reaction to drugs.
8. Procedures, techniques, and routines for giving general care such as bathing, shaving, shampooing, oral hygiene, nail care, shaving and scrubbing body area for surgery; administering medications; inserting catheter and nasogastric tube; giving enema; clothing and covering for transfer to operating room; preparing X-ray series and patient's record, including standard forms for anesthesia, tissue examination, operative report, authorization for anesthesia, blood transfusion (if required) and surgery check-off list or card; and recording on the nursing notes and nursing care plan.

9. Precautionary measures relative to shaving operative site; allergic reactions; and patient's clothing and/or covering for transfer to operating room.

Instructional Strategies

1. Pretest and/or review on general patient care day before surgery and day of surgery; administration of medications; giving enema; insertion of catheter and nasogastric tube; observation and communication skills as related to preoperative preparation; verification of doctor's orders and patient's identity; routines for recording and reporting.
2. Slides, filmstrips, films, videotapes, and/or mediated programmed instruction (individual or group) on all preoperative routines, procedures, and techniques sequenced in order that they are to be accomplished, with emphasis on body areas to be shaved and scrubbed for different types of operations; check-off list or card for surgery; preparation of patient for transfer to the operating room; patient's record preparation.
3. Hardcover programmed instruction
4. Lecture
5. Discussion
6. Demonstration
7. Role playing
8. Practice in simulated patient care unit
9. Practice in work situation
10. Study assignments
11. Written exercises

Training Aids

1. Filmstrips/films/videotapes
2. Mediated programmed instruction
3. Hardcover programmed instruction
4. Slides
5. Wall charts
6. Chalk board
7. Anatomical models
8. Equipment and supplies

9. Instructor's guide
10. Student syllabus
11. References

Examination Modes

1. Response in classroom
2. Paper and pencil test
3. Rating on performance in simulated practice
4. Rating on performance in work situation (feedback)
5. Oral quiz on knowledge related to performance in simulated practice and/or work situation (feedback)

Training Time

- 1:00 hour didactic
- 1:00 hour supervised practice

LEARNING MODULE IR3
POSTOPERATIVE UNIT: PREPARATION OF

Tasks

- _____ Prepare postoperative unit
- _____ Make postoperative/recovery bed
- _____ Set up intravenous stand
- _____ Set up oxygen therapy equipment
- _____ Set up equipment for indwelling catheter drainage system
- _____ Set up equipment for open/closed upper gastrointestinal drainage system with/without suction
- 150046 Arrange room/unit for individual patient's needs, e.g., blind, bedridden, postoperative
- 250025 Read equipment manuals for operation and maintenance of equipment

Performance Objective (Stimulus)

When assigned by the doctor, nurse, or senior corpsman/technician to prepare the postoperative unit.

Performance Objective (Behavior)

The corpsman/technician will assemble the necessary equipment and supplies; make the postoperative or recovery bed; set up the bedside table; and have ready at bedside the sphygmomanometer and stethoscope, infusion stand, oxygen and oxygen equipment, suction equipment, drainage equipment, side rails, plotting chart, and intake and output record with pencil.

Performance Objective (Conditions)

With indirect supervision and without assistance.

Performance Objective (Criteria)

According to established routines, procedures, and techniques.

Performance Objective (Consequence)

A complete, properly equipped, and prepared postoperative unit.

Performance Objective (Next Action)

Assist in transferring postoperative patient from stretcher to bed.

Knowledge and Skills

1. Purpose of the unit--recovery bed and all equipment and supplies in it
2. Patient's diagnosis, therapy, and condition as related to preparation of the unit
3. Procedures, techniques, and routines for making surgical bed; setting up bedside table, blood pressure equipment, infusion stand, oxygen equipment, drainage and suction equipment, side rails, and special records such as intake and output record and plotting chart.
4. Precautionary measures relative to all equipment being in working order and ability to operate it.

Instructional Strategies

1. Pretest and/or review on use of blood pressure, oxygen, drainage, and suction equipment; side rails; intake and output record and plotting chart.
2. Slides, filmstrips, films, videotapes, and/or mediated programmed instruction (individual or group) on making of recovery bed; setting up and arranging postoperative unit.
3. Hardcover programmed instruction
4. Lecture
5. Discussion
6. Demonstration
7. Practice in simulated patient care unit
8. Practice in work situation
9. Study assignments
10. Written exercises

Training Aids

1. Filmstrips/films/videotapes
2. Mediated programmed instruction
3. Hardcover programmed instruction
4. Slides

5. Chalk board
6. Equipment and supplies
7. Instructor's guide
8. Student syllabus
9. References

Examination Modes

1. Response in classroom
2. Paper and pencil test
3. Rating on performance in simulated practice
4. Rating on performance in work situation (feedback)
5. Oral quiz on knowledge related to performance in simulated practice and/or work situation (feedback)

Training Time

- 0:30 hour didactic
- 0:45 hour supervised practice

LEARNING MODULE IR4
PATIENT CARE: POSTOPERATIVE

Tasks

- 110128 Move/position comatose/anesthetized patient
- 130014 Check patient's pulse
- _____ Observe for/report symptoms of abnormal pulse
- 130404 Check/count respirations
- 130099 Observe for/report and describe abnormal respirations
- 130407 Check blood pressure
- 130636 Observe for/report symptoms of hypotension/hypertension
- 150113 Determine need to check vital signs more/less often than ordered by the doctor
- 130407 Check color of skin, e.g., cyanosis, blanching, jaundice, mottling
- 130110 Perform circulation check, e.g., color, pulse, temperature of skin, capillary return
- 130019 Check patient's airway for patency/obstruction
- 140276 Suction nasal/oral passage
- 140172 Suction trachea, i.e., deep endotracheal suction
- 140106 Stimulate/arouse patient after anesthesia
- 130393 Observe/report patient's level of consciousness
- 330328 Cross check medication and treatment card with KARDEX and doctor's orders
- 130057 Observe for/report symptoms of shock
- 140086 Give oxygen therapy, i.e., cannula, catheter, mask
- 140290 Give oxygen therapy via tent
- 140057 Connect drainage tube to drainage equipment, e.g., bag, bottle, machine
- 140268 Maintain drainage system, i.e., secure, position, and milk drainage tubes
- 130423 Observe/record and describe characteristics of drainage from internal body organs
- 130271 Observe for symptoms of external hemorrhage
- 130073 Estimate and record blood loss following hemorrhage
- 130424 Observe/record and describe characteristics of drainage from incisions/wounds

- 130007 Check dressings, e.g., for cleanliness
- 110103 Apply binders, e.g., T, scultetus, breast
- 140146 Regulate I.V. flow within standard limits
- 140002 Regulate blood transfusion flow
- 140284 Add/change I.V. bottle during continuous infusion
- 130388 Observe/record or describe characteristics of urine, feces, vomitus, or regurgitation
- 130431 Check/observe elimination patterns, e.g., frequency, urgency, incontinence
- 150191 Evaluate patient's inability to void
- 130436 Evaluate patient's complaints/symptoms of pain
- 140011 Administer subcutaneous medications
- 110091 Adjust side rails/height of bed for patient comfort/safety
- 250039 Plot readings/values on rectilinear graph paper
- 130009 Record/tally fluid intake and output
- 150064 Write nursing notes
- 150069 Give/receive verbal reports about patient
- 150035 Give report on changes/special care/treatment/tests for patient

Performance Objective (Stimulus)

When assigned by the doctor, nurse, or senior corpsman/technician to receive and care for a postoperative patient immediately following surgery.

Performance Objective (Behavior)

The corpsman/technician will assist in moving patient from stretcher to bed and positioning him in bed; take vital signs and observe for any abnormalities; check airway for patency and suction nasal/oral passage and trachea as needed; arouse patient or evaluate level of consciousness or presence of shock; check doctor's postoperative orders and follow relating to administration of oxygen, intravenous fluids, blood and medication; check dressing for hemorrhage or drainage and apply binder if ordered; connect Foley catheter and drainage tubes if inserted; observe for nausea, vomiting, and voiding (if no catheter); record findings on appropriate graph sheet, input and output record, and nursing notes; and report patient's condition and changes in condition to supervisor.

Performance Objective (Conditions)

With indirect supervision and with or without assistance, depending on patient's condition.

Performance Objective (Criteria)

In accordance with established standard procedure, techniques, and routines.

Performance Objective (Consequence)

Patient will receive the needed postoperative care immediately following surgery.

Performance Objective (Next Action)

Make the patient as comfortable as possible and observe him closely.

Knowledge and Skills

1. Purpose of postoperative routines, procedures, and techniques
2. Anatomy and physiology of cardiovascular, respiratory, digestive, and excretory systems and the system involved in surgery.
3. Communication techniques for giving information to and eliciting it from the patient and for reporting to supervisory personnel.
4. Observation techniques for assessing the patient's condition and response following surgery
5. Routine for verification of doctor's orders and patient's identity
6. Patient's diagnosis, therapy, and condition as related to postoperative care
7. Criteria for contraindications for movement and positioning
8. Procedures, techniques, and routines for moving; positioning; taking vital signs; suctioning nasal/oral passage and trachea; starting oxygen by mask, catheter or tent; monitoring intravenous fluids and/or transfusion; attaching drainage tubes and monitoring their functioning; applying binders; observing airway patency, wound hemorrhage or drainage, level of consciousness and/or degree of shock, voiding or catheter drainage and symptoms of pain and nausea; administering subcutaneous medications; preventing vomitus aspiration; recording on proper records vital signs, intake and output, and patient's condition and reporting same to supervisor.
9. Precautionary measures relative to aspiration, hemorrhage, and shock

Instructional Strategies

1. Pretest and/or review on verification of patient's identity and doctor's orders; communication and observation skills; procedures, techniques, and routines for moving; positioning; taking vital signs; suctioning nasal/oral passage and trachea; starting oxygen by mask, catheter or tent; monitoring intravenous fluids and/or transfusion; attaching drainage tubes and monitoring their functioning; applying binders; observing airway patency, wound hemorrhage or drainage, level of consciousness and/or degree of shock, voiding or catheter drainage and symptoms of pain and nausea; administering subcutaneous medications; preventing vomitus aspiration; recording on proper records vital signs, intake and output, and patient's condition and reporting same to supervisor.
2. Slides, filmstrips, films, videotapes, and/or mediated programmed instruction (individual or group) on sequence in which postoperative routines, procedures, and techniques are performed for patient on return from surgery.
3. Hardcover programmed instruction
4. Lecture
5. Discussion
6. Demonstration
7. Practice in simulated patient care unit
8. Practice in work situation
9. Study assignments
10. Written exercises
11. Problem solving situations

Training Aids

1. Filmstrips/films/videotapes
2. Mediated programmed instruction
3. Hardcover programmed instruction
4. Slides
5. Wall charts
6. Chalk board
7. Anatomical models
8. Equipment and supplies
9. Instructor's guide
10. Student syllabus
11. References

Examination Modes

1. Response in classroom
2. Paper and pencil test
3. Rating on performance in simulated practice
4. Rating on performance in work situation (feedback)
5. Oral quiz on knowledge related to performance in simulated practice and/or work situation (feedback)

Training Time

1:00 hour didactic

0:30 hour supervised practice

LEARNING MODULE IR5
SURGICAL WOUNDS: CHANGING DRESSINGS

Tasks

- 320328 Cross check medication and treatment card with KARDEX and doctor's orders
- 110063 Verify identification of patient, e.g., for treatment, medication, examination
- 120080 Inform patient of procedure prior to/during examination/test/treatment
- 150078 Ask patient/check chart for contraindication for treatment/test/procedure
- 120046 Reassure/calm apprehensive/anxious patient
- _____ Wash hands prior to/after patient care, medication, treatment, examination, procedure, specimen collecting and handling
- 145041 Arrange furniture, set up equipment/supplies for procedure, e.g., examination/treatment
- 110005 Assist patient in/out of bed, examination/O.R. table
- 110013 Drape/gown patient for examination/treatment
- 110081 Position/hold patient for examination, treatment, surgery
- 200003 Check instruments and supplies for sterilization
- 140020 Apply/change sterile dressings
- 140437 Apply/change abdominal dressings
- 140439 Apply/change head and neck dressings
- 140099 Apply/change dressings to open amputated stump
- 140436 Apply/change dressings to closed amputated stump
- 140440 Apply/change skin graft dressings
- 140438 Apply/change pedicle skin graft dressings
- 130401 Check/examine incisions/wounds for progress of healing
- 130259 Check for/report symptoms of wound infection
- 140127 Pack anal/pilonidal fissures
- 130424 Observe/record or describe characteristics of drainage from incisions and wounds
- 130436 Evaluate patient's complaints/symptoms of pain
- 130382 Observe/record patient's physical/emotional response to treatment/diagnostic procedure

- 150036 Inform doctor/nurse of patient's condition, e.g., description of symptoms, injuries, or response
- 230162 Wash glassware and instruments
- 230251 Disinfect instruments/material/equipment
- 150064 Write nursing notes
- _____ Record on nursing care plan

Performance Objective (Stimulus)

When assigned by the senior corpsman/technician, nurse, or doctor to change surgical dressings as ordered by the physician.

Performance Objective (Behavior)

The corpsman/technician will verify the doctor's orders and the patient's identity; communicate with the patient about the procedure; determine any contraindications for it; reassure the apprehensive patient; acquire the required equipment and supplies; assist patient to examining table and position and drape him, or position and drape him in bed; wash hands; open up sterile packages and check indicator for sterility; remove old dressings and apply new sterile ones to abdomen, back, chest, head and neck, amputated stumps, and other parts of the body including skin grafts; evaluate patient's general condition, healing process, presence of infection or drainage; and response to procedure; record on nursing notes and patient care plan; and clean up and take care of used equipment.

Performance Objective (Conditions)

With supervision and without assistance unless warranted by patient's condition.

Performance Objective (Criteria)

In accordance with established standard procedures, techniques, and routines.

Performance Objective (Consequence)

Patient will have a clean sterile dressing and an evaluation of his wound status.

Performance Objective (Next Action)

Make patient as comfortable as possible and check for any post-procedure reactions.

Knowledge and Skills

1. Purpose of changing surgical dressings
2. Anatomy and physiology as related to the healing process, hemorrhage, and infection
3. Sterile technique as related to surgical dressings
4. Communication skills for giving information to and eliciting it from the patient and for reporting to supervisory personnel.
5. Observation techniques as related to maintenance of sterility; patient's condition and response to procedure and condition of wound.
6. Routines for verification of doctor's orders and patient's identity
7. Patient's diagnosis, therapy, condition, and type of surgery as related to his dressing
8. Criteria for determining contraindications for any step in the surgical dressing procedure
9. Procedure and techniques for setting up for dressings; readying the patient for the procedure; removing and replacing surgical dressings; and recording on nursing notes and nursing care plan.
10. Precautionary measures relative to removal and replacement of surgical dressings
11. Routine for clean up and equipment care following procedure
12. Routine for suggesting changes in patient care and modifying patient care plan accordingly

Instructional Strategies

1. Pretest and/or review on communication and observation skills; routines for verifying doctor's orders and patient's identity; anatomy and physiology as related to healing process, infection, drainage and hemorrhage; routines for reporting and recording.
2. Slides, filmstrips, films, videotapes, and/or mediated programmed instruction (individual or group) on purpose, procedure, techniques, and routines for readying the patient, setting up for surgical dressings, removing and replacing the dressing, and evaluating the status of the wound; determining contraindications for changing the dressing and maintaining sterile technique.

3. Hardcover programmed instruction
4. Lecture
5. Discussion
6. Demonstration
7. Practice in simulated patient care unit
8. Practice in work situation
9. Study assignments
10. Written exercises

Training Aids

1. Filmstrips/films/videotapes
2. Mediated programmed instruction
3. Hardcover programmed instruction
4. Slides
5. Wall charts
6. Chalk board
7. Anatomical models
8. Equipment and supplies
9. Instructor's guide
10. Student syllabus
11. References

Examination Modes

1. Response in classroom
2. Paper and pencil test
3. Rating on performance in simulated practice
4. Rating on performance in work situation (feedback)
5. Oral quiz on knowledge related to performance in simulated practice and/or work situation (feedback)

Training Time

1:00 hour didactic

1:00 hour supervised practice

LEARNING MODULE IR6
SURGICAL WOUNDS: PACKING AND DRAINS

Tasks

- 320328 Cross check medication and treatment card with KARDEX and doctor's orders
- 110063 Verify identification of patient, e.g., for treatment, medication, examination
- 120080 Inform patient of procedure prior to/during examination/test/treatment
- 150078 Ask patient/check chart for contraindication for treatment/test/procedure
- 120046 Reassure/calm apprehensive/anxious patient
- _____ Wash hands prior to/after patient care, medication, treatment, examination, procedure, specimen collecting and handling
- 145041 Arrange furniture, set up equipment/supplies for procedure, e.g., examination/treatment
- 110005 Assist patient in/out of bed, examination/O.R. table
- 110013 Drape/gown patient for examination/treatment
- 110081 Position/hold patient for examination, treatment, surgery
- 200003 Check instruments and supplies for sterilization
- 140020 Apply/change sterile dressings
- 110043 Prepare skin site with antiseptic solution prior to incision/suturing/treatment/examination
- 140154 Remove/shorten drain
- 140128 Pack incision/wound/cavity
- 130401 Check/examine incisions/wounds for progress of healing
- 130259 Check for/report symptoms of wound infection
- 130424 Observe/record or describe characteristics of drainage from incisions and wounds
- 130436 Evaluate patient's complaints/symptoms of pain
- 130382 Observe/record patient's physical/emotional response to treatment/diagnostic procedure
- 150036 Inform doctor/nurse of patient's condition, e.g., description of symptoms, injuries, or response
- 230162 Wash glassware and instruments
- 230251 Disinfect instruments/material/equipment

150064 Write nursing notes

_____ Record on nursing care plan

Performance Objective (Stimulus)

When assigned by the senior corpsman/technician, nurse, or doctor to shorten and remove drain from surgical wounds or to pack incisions, wounds, and cavities as ordered by the physician.

Performance Objective (Behavior)

The corpsman/technician will follow the routines, procedures, and techniques for surgical dressing except that after removing the dressing he will shorten or remove the drains or will pack the incision, wound, or cavity prior to application of a new sterile dressing.

Performance Objective (Conditions)

With supervision and with or without assistance, depending upon the patient's condition.

Performance Objective (Criteria)

In accordance with established standard procedures, techniques, and routines.

Performance Objective (Consequence)

Patient will have drains shortened or removed and/or packing inserted into wounds, incision, or cavity.

Performance Objective (Next Action)

Make the patient as comfortable as possible and check for any untoward reaction.

Knowledge and Skills

1. Purpose and types of drains and packing
2. Anatomy and physiology as related to wounds and the use of drains and packing

3. Sterile technique as related to drain shortening or withdrawal and the packing of incisions, wounds, and cavities.
4. Procedures and techniques for changing surgical dressings
5. Communication skills for giving information to and eliciting it from the patient and reporting to supervisory personnel.
6. Observation techniques as related to maintenance of sterility, condition of the wound and the patient's condition and response to procedure.
7. Routine for verification of doctor's orders and patient's identity
8. Patient's diagnosis, therapy, condition, and type of surgery as related to wounds, drains, and/or packing.
9. Criteria for determining contraindications for the procedure
10. Procedures and techniques for shortening or removing drains; packing incisions, wounds, and cavities; and recording on nursing notes and nursing care plan.
11. Precautionary measures relative to drain shortening or removal and packing incisions, wounds, and cavities.
12. Routine for clean up and care of equipment following procedure
13. Routine for suggesting changes in patient care and modifying nursing care plan accordingly.

Instructional Strategies

1. Pretest and/or review on communication and observation skills; routines for verifying doctor's orders and patient's identity; anatomy and physiology as related to the healing process, infection, drainage, and hemorrhage; procedure and technique for changing surgical dressings and evaluating status of wound; and routines for reporting and recording.
2. Slides, filmstrips, films, videotapes, and/or mediated programmed instruction (individual or group) on procedures and techniques for shortening and removing drains, packing incisions, wounds, and cavities; and the contraindications and precautions related to these procedures.
3. Hardcover programmed instruction
4. Lecture
5. Discussion
6. Demonstration
7. Practice in simulated patient care unit and/or work situation--coordinate with Learning Module IR7, "Surgical Wounds: Irrigations," and Learning Module IR8, "Surgical Wounds: Suture Removal."
8. Study assignments
9. Written exercises

Training Aids

1. Filmstrips/films/videotapes
2. Mediated programmed instruction
3. Hardcover programmed instruction
4. Chalk board
5. Anatomical models
6. Equipment and supplies
7. Instructor's guide
8. Student syllabus
9. References

Examination Modes

1. Response in classroom
2. Paper and pencil test
3. Rating on performance in simulated practice
4. Rating on performance in work situation (feedback)
5. Oral quiz on knowledge related to performance in simulated practice and/or work situation (feedback)

Training Time

0:15 hour didactic

0:20 hour supervised practice coordinated with Learning Modules IR7 and IR8

LEARNING MODULE IR7
SURGICAL WOUNDS: IRRIGATIONS

Tasks

- 320328 Cross check medication and treatment card with KARDEX and doctor's orders
- 110063 Verify identification of patient, e.g., for treatment, medication, examination
- 120080 Inform patient of procedure prior to/during examination/test/treatment
- 150078 Ask patient/check chart for contraindication for treatment/test/procedure
- 120046 Reassure/calm apprehensive/anxious patient
- _____ Wash hands prior to/after patient care, medication, treatment, examination, procedure, specimen collecting and handling
- 145041 Arrange furniture, set up equipment/supplies for procedure, e.g., examination/treatment
- 110005 Assist patient in/out of bed, examination/O.R. table
- 110013 Drape/gown patient for examination/treatment
- 110081 Position/hold patient for examination, treatment, surgery
- 200003 Check instruments and supplies for sterilization
- 140020 Apply/change sterile dressings
- 140119 Irrigate wounds
- 130401 Check/examine incisions/wounds for progress of healing
- 130259 Check for/report symptoms of wound infection
- 130424 Observe/record or describe characteristics of drainage from incisions and wounds
- 130436 Evaluate patient's complaints/symptoms of pain
- 130382 Observe/record patient's physical/emotional response to treatment/diagnostic procedure
- 150036 Inform doctor/nurse of patient's condition, e.g., description of symptoms, injuries, or response
- 230162 Wash glassware and instruments
- 230251 Disinfect instruments/material/equipment
- 150064 Write nursing notes
- _____ Record on nursing care plan

Performance Objective (Stimulus)

When assigned by the senior corpsman/technician, nurse, or doctor to irrigate wounds as ordered by the physician.

Performance Objective (Behavior)

The corpsman/technician will follow the routine, procedures, and techniques for changing surgical dressing, except that after removing the dressing, he will irrigate the wound prior to application of a new sterile dressing.

Performance Objective (Conditions)

With supervision and with or without assistance, depending upon the patient's condition.

Performance Objective (Criteria)

In accordance with established standard procedure, techniques, and routines for sterile irrigations of wounds.

Performance Objective (Consequence)

Patient's wound will be irrigated following removal of old dressing and before application of new sterile one.

Performance Objective (Next Action)

Make the patient as comfortable as possible and observe for any untoward reaction.

Knowledge and Skills

1. Purpose of wound irrigations
2. Anatomy and physiology as related to wound healing, infection, and drainage
3. Sterile techniques for wound irrigations
4. Procedures and techniques for changing surgical dressings
5. Communication techniques for giving information to and eliciting it from the patient and reporting to supervisory personnel.

6. Observation techniques as related to maintenance or sterility, results of irrigation, condition of wound, and patient's condition and response to procedure.
7. Routine for verification of doctor's orders and patient's identity
8. Patient's diagnosis, therapy, condition, and type of surgery as related to irrigation procedure and condition of wound.
9. Criteria for determining contraindications for wound irrigation, such as hemorrhage
10. Procedure and techniques for irrigating wounds and recording on nursing notes and nursing care plan
11. Precautionary measures relative to irrigating wounds
12. Routine for clean up and care of equipment following procedure
13. Routine for suggesting changes in patient care and modifying nursing care plan accordingly

Instructional Strategies

1. Pretest and/or review on communication and observation skills; routines for verifying doctor's orders and patient's identity; anatomy and physiology as related to the healing process, infection, drainage, and hemorrhage; procedure, techniques, and routines for changing surgical dressings and evaluating status of wound; and routines for reporting and recording.
2. Slides, filmstrips, films, videotapes, and/or mediated programmed instruction (individual or group) on procedure, techniques, and routines for irrigating surgical wounds and contraindication and precautionary measures related to procedure.
3. Hardcover programmed instruction
4. Lecture
5. Discussion
6. Demonstration
7. Practice in simulated patient care unit and/or work situation--coordinate with Learning Module IR6, "Surgical Wounds: Packing and Drains," and Learning Module IR8, "Surgical Wounds: Suture Removal."
8. Study assignments
9. Written exercises

Training Aids

1. Filmstrips/films/videotapes
2. Mediated programmed instruction

3. Hardcover programmed instruction
4. Slides
5. Chalk board
6. Anatomical models
7. Equipment and supplies
8. Instructor's guide
9. Student syllabus
10. References

Examination Modes

1. Response in classroom
2. Paper and pencil test
3. Rating on performance in simulated practice
4. Rating on performance in work situation (feedback)
5. Oral quiz on knowledge related to performance in simulated practice and/or work situation (feedback)

Training Time

0:15 hour didactic

0:20 hour supervised practice coordinated with Learning Modules IR6 and IR8

LEARNING MODULE IR8
SURGICAL WOUNDS: SUTURE REMOVAL

Tasks

- 320328 Cross check medication and treatment card with KARDEX and doctor's orders
- 110063 Verify identification of patient, e.g., for treatment, medication, examination
- 120080 Inform patient of procedure prior to/during examination/test/treatment
- 150078 Ask patient/check chart for contraindication for treatment/test/procedure
- 120046 Reassure/calm apprehensive/anxious patient
- _____ Wash hands prior to/after patient care, medication, treatment, examination, procedure, specimen collecting and handling
- 145041 Arrange furniture, set up equipment/supplies for procedure, e.g., examination/treatment
- 110005 Assist patient in/out of bed, examination/O.R. table
- 110013 Drape/gown patient for examination/treatment
- 110081 Position/hold patient for examination, treatment, surgery
- 200003 Check instruments and supplies for sterilization
- 140020 Apply/change sterile dressings
- 110043 Prepare skin site with antiseptic solution prior to incision/suturing/treatment/examination
- 140158 Remove sutures
- 130401 Check/examine incisions/wounds for progress of healing
- 130259 Check for/report symptoms of wound infection
- 130424 Observe/record or describe characteristics of drainage from incisions and wounds
- 130436 Evaluate patient's complaints/symptoms of pain
- 130382 Observe/record patient's physical/emotional response to treatment/diagnostic procedure
- 150036 Inform doctor/nurse of patient's condition, e.g., description of symptoms, injuries, or response
- 230162 Wash glassware and instruments
- 230251 Disinfect instruments/material/equipment
- 150064 Write nursing notes
- _____ Record on nursing care plan

Performance Objective (Stimulus)

When assigned by the senior corpsman/technician, nurse, or doctor to remove sutures as ordered by the physician.

Performance Objective (Behavior)

The corpsman/technician will follow the routines, procedures, and techniques for changing surgical dressings, except that he will add a suture removal tray or package to his equipment and after removing the dressing, will clip and remove the sutures from the wound prior to application of a new sterile dressing.

Performance Objective (Conditions)

With supervision and with or without assistance, depending upon the patient's condition.

Performance Objective (Criteria)

In accordance with established standard procedure, techniques, and routines for removing sutures from surgical wounds.

Performance Objective (Consequence)

Sutures will be removed from patient's wound.

Performance Objective (Next Action)

Make the patient as comfortable as possible and observe for any untoward reaction.

Knowledge and Skills

1. Purpose of suture removal
2. Types of suture material and kinds of skin suturing
3. Anatomy and physiology as related to wound healing, infection, and drainage
4. Required equipment and sterile technique for suture removal
5. Communication techniques for eliciting information from and giving it to the patient and reporting to supervisory personnel.

6. Observation techniques as related to maintenance of sterility, suture removal, and condition of wound and patient's condition and response to procedure.
7. Routine for verification of doctor's orders and patient's identity
8. Patient's diagnosis, therapy, condition, and postoperative days as related to removal of sutures.
9. Criteria for determining contraindications for removal of all or part of sutures, such as infection.
10. Procedure and techniques for removing sutures and recording on nursing notes and nursing care plan.
11. Precautionary measures relative to suture removal
12. Routine for clean up and care of equipment following procedure
13. Routine for suggesting changes in patient care and modifying nursing care plan accordingly

Instructional Strategies

1. Pretest and/or review on communication and observation skills; routines for verifying doctor's orders and patient's identity; anatomy and physiology as related to the healing process, infection, drainage, and hemorrhage; procedure and technique for changing surgical dressings and evaluating status of wound; and routines for reporting and recording.
2. Slides, filmstrips, films, videotapes, and/or mediated programmed instruction (individual or group) on procedures and techniques for removing sutures from surgical wounds, types of sutures and kinds of suturing, and contraindications and precautionary measures related to procedure.
3. Hardcover programmed instruction
4. Lecture
5. Discussion
6. Demonstration
7. Practice in simulated patient care unit and/or work situation--coordinate with Learning Module IR6, "Surgical Wounds: Packing and Drains," and Learning Module IR7, "Surgical Wounds: Irrigations."
8. Study assignments
9. Written exercises

Training Aids

1. Filmstrips/films/videotapes
2. Mediated programmed instruction

3. Hardcover programmed instruction
4. Slides
5. Chalk board
6. Anatomical models
7. Equipment and supplies
8. Instructor's guide
9. Student syllabus
10. References

Examination Modes

1. Response in classroom
2. Paper and pencil test
3. Rating on performance in simulated practice
4. Rating on performance in work situation (feedback)
5. Oral quiz on knowledge related to performance in simulated practice and/or work situation (feedback)

Training Time

0:15 hour didactic

0:20 hour supervised practice coordinated with Learning Modules IR6 and IR7